

**Modern Eyecare - Confidential Medical History**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Male  Female

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Name of medical doctor: \_\_\_\_\_

List any allergies to medicines: \_\_\_\_\_

List any medications you take (including birth control pills, aspirin, over-the-counter medications, and home remedies)

List all major injuries, surgeries, and hospitalization you have had: \_\_\_\_\_

Last physical exam: \_\_\_\_\_ Last eye exam: \_\_\_\_\_ Are you pregnant or nursing? Yes  No

Who may we thank for referring you?  Insurance  Phone Book  Newspaper

Friend/Family Member: \_\_\_\_\_

EYEWEAR HISTORY

Do you wear glasses? Yes  No

Bifocals  Trifocals  No Line Bifocals  Reading Glasses Only

Do you wear contact lenses? Yes  No

Soft Contact Lenses  Gas Permeable Contact Lenses  Multifocal or Monovision

Have you had LASIK / Refractive Surgery ? Yes  No

PERSONAL/FAMILY HISTORY

Please answer the question below regarding you or your family (parents, grandparents, siblings, children) for the following:

	You		Family		?	Relationship
	Yes	No	Yes	No		
Blindness/Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Please choose all that apply:

- Tobacco Use
- Student
- Fishing
- Occupation \_\_\_\_\_
- Alcohol Use
- Computer Use
- Music
- Drug Abuse
- Reading
- Sports
- Employer \_\_\_\_\_
- Non-Smoker
- Golf
- Swimming

**REVIEW OF SYSTEMS**

Do you currently have or have you ever had any problems in the following areas:

	Yes	No	?		Yes	No	?
<b>Constitutional</b>				<b>Ears/Nose, Mouth, Throat</b>			
Fever/weight changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Integumentary (Skin)</b>				<b>Respiratory</b>			
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>				<b>Vascular/Cardiovascular</b>			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b>			
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eyes</b>				<b>Genitourinary</b>			
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision/halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Bones/Joints/Muscles</b>			
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lymphatic/Hematologic</b>			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Psychiatric</b>			
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other</b> _____			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Eye trauma/injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Floater in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Endocrine</b>							
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

**LIFESTYLE QUESTIONS**

Do you...? (Please mark all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Plan to get new glasses today?                          | <input type="checkbox"/> Have more than 1 pair of current prescription eyewear? |
| <input type="checkbox"/> Spend time outdoors?                                    | <input type="checkbox"/> Prefer not to wear glasses at times?                   |
| <input type="checkbox"/> Tend to scratch your glasses easily?                    | <input type="checkbox"/> Work on a computer?                                    |
| <input type="checkbox"/> Feel bothered by glare and reflections?                 | <input type="checkbox"/> Wear sunglasses when outside?                          |
| <input type="checkbox"/> Wish you had thinner, lighter, more comfortable lenses? | <input type="checkbox"/> Have an interest in trying contact lenses?             |

Our office requires payment at the time of service for all professional services and materials not covered in full by your insurance. By signing this form, you are authorizing Modern Eyecare to file your insurance claims for this and all following visits. You are also acknowledging that you agree to Modern Eyecare's Financial Policy Agreement. You are responsible for all fees that your insurance will not cover. Your information is protected by our privacy policy. Your signature here acknowledges that you have received a copy of Modern Eyecare's Notice of Privacy Practices and consent to Modern Eyecare's use and/or disclosure of your protected health information to carry out treatment, payment, and healthcare operations.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_