Modern Eyecare - Confidential Medical History **Date:_____**

Name:_____ Date of birth:__/___/_____ SS #_____ Male □ Female □

Address:_____City/State/Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Name of Spouse/Parent (circle one):_____ Medical doctor:_____

List any allergies to medicines:_____

List any medicines you take with dosage/frequency (including birth control, aspirin, OTC 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 □

Race
□ White
□ Hispanic or Latino
□ Asian
□ Black/African American
□ American Indian/Alaska Native
□ Native Hawaiian/Other Pacific Islander
□ Prefer not to specify

Ethnicity
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Native Hawaiian/Other Pacific Islander
□ Prefer not to specify

Communication Preference
□ Telephone
□ Email
□ Mail

Preferred Language
□ English
□ Other _____

Who may we thank for referring you to our office?
□ Insurance
□ Phone Book
□ Newspaper
□ Friend:_____
_____

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 (Parent, Sibling, etc)**
	Yes	**No**	**Yes**	**No**	**?**	
Crossed Eyes/Lazy Eye	□	□	□	□	□	_____
Glaucoma	□	□	□	□	□	_____
Macular Degeneration	□	□	□	□	□	_____
Retinal Detachment	□	□	□	□	□	_____
Cataracts	□	□	□	□	□	_____
Cancer	□	□	□	□	□	_____
Diabetes	□	□	□	□	□	_____
Heart Disease	□	□	□	□	□	_____
High Blood Pressure	□	□	□	□	□	_____
High Cholesterol	□	□	□	□	□	_____
Thyroid Disease	□	□	□	□	□	_____
Other_____	□	□	□	□	□	_____

Approximate Height:_____ Approximate Weight:_____

SOCIAL HISTORY Please choose all that apply:

☐ Student	Alcohol Use	Tobacco Use	Occupation_____
☐ Reading	☐ None	☐ Non-Smoker	
☐ Swimming	☐ Social Use Only	☐ Former Smoker	Employer_____
☐ Sports	☐ Daily Use	☐ Light Smoker	
☐ Golf	☐ Above Average Use	☐ Heavy Smoker	
☐ Fishing	☐ Alcohol Dependence	☐ Smokeless Tobacco User	☐ Recreational Drug Use

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

	Yes	No	?
Constitutional			
Fever/weight changes	☐	☐	☐
Integumentary (Skin)			
Rosacea	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Parkinson's Disease	☐	☐	☐
Eyes			
Blurred vision	☐	☐	☐
Distorted vision/halos	☐	☐	☐
Loss of side vision	☐	☐	☐
Double vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or gritty feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Glare/light sensitivity	☐	☐	☐
Foreign body sensation	☐	☐	☐
Eye pain or soreness	☐	☐	☐
Eye trauma/injury	☐	☐	☐
Flashes	☐	☐	☐
Floaters in vision	☐	☐	☐
Psychiatric			
Anxiety/Depression	☐	☐	☐

	Yes	No	?
Ears/Nose, Mouth, Throat			
Allergies/hay fever	☐	☐	☐
Sinus congestion	☐	☐	☐
Dry throat, mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
Chronic bronchitis	☐	☐	☐
Vascular/Cardiovascular			
Heart/vascular disease	☐	☐	☐
High blood pressure	☐	☐	☐
High cholesterol	☐	☐	☐
Endocrine			
Diabetes	☐	☐	☐
Thyroid disease	☐	☐	☐
Gastrointestinal			
Acid Reflux	☐	☐	☐
Genitourinary			
Kidney/bladder disorder	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid arthritis	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding problems	☐	☐	☐
Other_____			

LIFESTYLE QUESTIONS Do you…? (Please mark all that apply)

- ☐ Plan to get new glasses today?
- ☐ Spend time outdoors?
- ☐ Tend to scratch your glasses easily?
- ☐ Feel bothered by glare and reflections?
- ☐ Wish you had thinner, lighter, more comfortable lenses?
- ☐ Have more than 1 pair of current prescription eyewear?
- ☐ Prefer not to wear glasses at times?
- ☐ Work on a computer?
- ☐ Wear sunglasses when outside?
- ☐ 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 subsequent 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:_____