

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
- 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
- Prefer not to specify

Who may we thank for referring you to our office?

- Insurance Company
- Phone Book
- Newspaper/Ad/Website
- Doctor
- Friend/Family Member: _____

Communication Preference

- Telephone
- Email
- Mail

Preferred Language

- English
- Other _____

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 (Mother, Brother, etc)
	Yes	No	Yes	No		
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"/>	_____
High Cholesterol	<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"/>	_____

Approximate Height: _____

Approximate Weight: _____

SOCIAL HISTORY Please choose all that apply:

- | | | | |
|-----------------------------------|--|--|------------------|
| <input type="checkbox"/> Student | <u>Alcohol Use</u> | <u>Tobacco Use</u> | Occupation _____ |
| <input type="checkbox"/> Reading | <input type="checkbox"/> None | <input type="checkbox"/> Never Smoked | |
| <input type="checkbox"/> Swimming | <input type="checkbox"/> Less than 1 Drink/Day | <input type="checkbox"/> Former Smoker | Employer _____ |
| <input type="checkbox"/> Sports | <input type="checkbox"/> 1-2 Drinks/Day | <input type="checkbox"/> Everyday Smoker | |
| <input type="checkbox"/> Golf | <input type="checkbox"/> 3+ Drinks/Day | | |
| <input type="checkbox"/> Fishing | | | |

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

	Yes	No		Yes	No
Constitutional			Ears/Nose, Mouth, Throat		
Fever/weight changes	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
			Dry throat, mouth	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)			Respiratory		
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>
Neurological			Vascular/Cardiovascular		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Heart/vascular disease	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Eyes			Endocrine		
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision/halos	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary		
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder disorder	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Bones/Joints/Muscles		
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/Hematologic/Immunologic		
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Eye trauma/injury	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Floaters in vision	<input type="checkbox"/>	<input type="checkbox"/>			
Flashes	<input type="checkbox"/>	<input type="checkbox"/>			
Psychiatric					
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>			
Depression	<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 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: _____