**MEDICAL HISTORY FORM**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**GENDER: Male/Female SSN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ADDRESS, CITY, STATE & ZIP CODE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CELL PHONE NUMBER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **EMAIL ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PRIMARY CARE DOCTOR:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE CARRIER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PRIMARY MEMBER OF INS. NAME/DOB:** **MEMBER ID:**

**REFERRED BY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PHARMACY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PHONE/ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **HOBBIES:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MEDICATION ALLERGIES:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NAME OF RESPONSIBLE PARTY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_REASON FOR YOUR VISIT TODAY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU WANT TO HAVE A REFRACTION (A DIAGNOSTIC TEST) TO UPDATE YOUR GLASSES? YES \_\_\_ NO \_\_ DO YOU HAVE A VISION INS PLAN? \_\_YES / NO**

**CONTACT LENS HISTORY: DO YOU CURRENTLY WEAR CONTACTS? YES NO \_\_\_\_ WOULD YOU LIKE A CONTACT LENS EVALUATION TODAY? YES NO**

**Would you like to receive communications from us via email? YES \_\_\_\_\_ NO\_\_\_\_\_**  \*\*\*\*\**Reviewed by FD* \_\_\_\_\_\_

**DO YOU CURRENTLY, OR DID YOU EVER, HAVE PROBLEMS IN THE FOLLOWING AREAS? IF YES, PLEASE PROVIDE EXPLANATION**:

**MEDICAL HISTORY** **YES NO EXPLANATION OF PROBLEM**

|  |  |  |  |
| --- | --- | --- | --- |
| Cardiovascular (Heart Disease, High Blood Pressure, etc.) |  |  |  |
| Neurological |  |  |  |
| Gastrointestinal |  |  |  |
| Kidney, Bladder |  |  |  |
| Skin |  |  |  |
| Psychiatric |  |  |  |
| Eyes, Ears, Nose, Throat |  |  |  |
| Endocrine/Diabetes/Thyroid Disease |  |  |  |
| Respiratory |  |  |  |
| Muscles, Bones, Joints |  |  |  |
| Cancer |  |  |  |
| List all major illnesses and injuries, including surgeries (other than eyes) |  |  |  |

**OCULAR HISTORY YES NO EXPLANATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Glaucoma |  |  |  |
| Macular Degeneration / OTHER |  |  |  |
| List all eye surgeries (date/physician) |  |  |  |

**FAMILY HISTORY YES NO RELATIONSHIP TO PATIENT**

|  |  |  |  |
| --- | --- | --- | --- |
| Crossed Eyes / Blindness |  |  |  |
| Glaucoma |  |  |  |
| Retinal Disease / OTHER |  |  |  |

**SOCIAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you drive? **YES /NO**  Pregnant or Breast Feeding? **YES/NO** | Do you drink? **YES /NO**  Do you smoke? **YES/NO** | **Single/Married/ Widowed** | **Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_** |

**SIGNATURE OF RESPONSIBLE PARTY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *REVIEWED BY DR*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**