vitaleyes

PATIENT MEDICAL HISTORY FORM

(440) 846-3937

Name_____ Date of Birth _____ Today's Date_____

If a minor, name of parent/guardian _____ Phone (_____)_____

Emergency Contact _____Relationship_____ Phone (_____)_____

Whom may we thank for referring you to us? _____

When was your last visit to an eye doctor?_____ Where? _____

When was your last Physical Exam? _____ Who is your Primary Care Provider?_____

Circle all of the following that apply to you now or have in the past:

Blurry distance vision	Burning	Floaters/spots	Headaches	Head Injury/ Concussion
Blurry near vision	Itching	Flashing lights	Migraines	Eye Surgery
Double vision	Dryness	Poor night vision	Crossed/Turned Eyes	Eye Infection
Watery eyes	Sandy/gritty feeling	Droopy Lid	Eye Pain	Eye Injury

Do you currently wear glasses? Yes / No All the time / Computer / Reading / Driving

Are you interested in contact lenses? Yes / No Have you worn contact lenses in the past? Yes / No

Do you currently wear contact lenses? Yes / No Type: _____

What is your occupation? _____ Do you work on a computer? Y / N Hours/Day ____

What are your hobbies? _____

Do you smoke or use tobacco products? Yes / No Are you currently pregnant? Yes / No Nursing? Yes / No

List current medications (or provide list) _____

_____

List ALLERGIES_____

PERSONAL AND FAMILY MEDICAL HISTORY

Please check the appropriate box for each condition

Self	Family	NA		
❑	❑	❑	Glaucoma	
❑	❑	❑	Cataracts	
❑	❑	❑	Macular Degeneration	
❑	❑	❑	Retinal Detachment	
❑	❑	❑	Crossed/Lazy Eye	
❑	❑	❑	Other Eye Disease	
❑	❑	❑	Diabetes Type 1 / Type 2 Last A1C _____	
❑	❑	❑	Hypertension	
❑	❑	❑	Heart Disease	
❑	❑	❑	Multiple Sclerosis	
❑	❑	❑	Head Injury/Concussion	
❑	❑	❑	Other Autoimmune Disease	Type _____
❑	❑	❑	Cancer	Type _____
❑	❑	❑	OTHER _____	