Medical History Form

Patient Information

Title | First Name | Last Name | MI | Suffix | Nickname

Address | Apt/Suite #

City | State | ZipCode

Home Phone | Work Phone

Cell Phone | Other Phone

Preferred Contact Method:
☐Home Phone ☐Work Phone ☐Cell Phone ☐Other Phone ☐Email

___-___-____ Social Security Number | __/__/__ Birthday | Email Address

Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Employment Status: ☐Employed ☐Full-Time Student ☐Part-Time Student

Occupation | School/Employer Name

Billing Information

Please fill out if the billing information/address is different from above.

Title | First Name | Last Name | MI | Suffix | Nickname

Address | Apt/Suite #

City | State | ZipCode

Home Phone | Work Phone

Vision Insurance

Insurance Name _____ Plan Number _____

Insurance ID _____ Policy Group _____

If you are not the primary insurance holder, please fill out the information below.

First Name _____ Last Name _____ MI _____

Relationship to Insured: ☐Spouse ☐Child ☐Other Sex: ☐Male ☐Female

Address _____ Apt/Suite # _____

City _____ State _____ ZipCode _____

Social Security Number ___-___-___ Birthday ___/___/___ Phone Number _____

Medical Insurance

Insurance Name _____ Plan Number _____

Insurance ID _____ Policy Group _____

If you are not the primary insurance holder, please fill out the information below.

First Name _____ Last Name _____ MI _____

Relationship to Insured: ☐Spouse ☐Child ☐Other Sex: ☐Male ☐Female

Address _____ Apt/Suite # _____

City _____ State _____ ZipCode _____

Social Security Number ___-___-___ Birthday ___/___/___ Phone Number _____

General Medical History

What is your reason for visiting our office today? _____

Do you take any prescription medications? _____

Do you take any over the counter medications? _____

Do you take any vitamins? _____

Are you allergic to any medications? _____

Please list any major injuries or surgeries you've had: _____

Primary Care Doctor: _____

Are you pregnant or nursing? ☐Yes ☐No ☐Not Sure

Have you had a recent tetanus shot? ☐Yes ☐No

Have you had a recent flu shot? ☐Yes ☐No

Review of Systems

Do you currently have any symptoms/conditions in the following categories?

General: _____

Ear/Nose/Throat: _____

Skin: _____

Cardiovascular: _____

Respiratory: _____

Muscles/Bones/Joints: _____

Psychiatric: _____

Gastrointestinal: _____

Endocrine: _____

Blood/Lymph: _____

Neurological: _____

Genitals/Urinary: _____

Allergy/Immune: _____

Personal and Family Medical History

Do you have any of these medical conditions? If yes, please describe:

Diabetes: _____

High Blood Pressure: _____

High Cholesterol: _____

Thyroid Conditions: _____

Heart Conditions: _____

Cancer: _____

Other: _____

Does anyone in your family have any of these medical conditions? If yes, please describe:

Diabetes: _____

High Blood Pressure: _____

High Cholesterol: _____

Thyroid Conditions: _____

Heart Conditions: _____

Cancer: _____

Other: _____

Social History

_____ _____

Hobbies STD History?

_____ _____ _____

Tobacco Use Type How Long

_____ _____ _____

Alcohol Use Type How Long

_____ _____ _____

Illegal Drug Use Type How Long

Eye History

Do you currently have any of these eye symptoms?:

☐Itching ☐Burning/Stinging ☐Red/Swollen Eyes ☐Floaters in Vision ☐Flashes of Light

☐Other _____

Do you take any eye medications? _____

Have you had any eye surgeries? _____

_____ _____

Last Eye Exam Which Office/Doctor?

Do you wear any glasses/contacts? _____

Do you have backup glasses? ☐Yes ☐No Do you want new glasses? ☐Yes ☐No

Do you want backup sunglasses? ☐Yes ☐No

Contact Lens Wearers Only

_____ _____

Type of Contacts Worn in the Past What cleaning solution do you use?

_____ _____

How often do you replace your lenses? How many hours per day do you wear your lenses?

Family Eye History

Who in your family has the following eye conditions?

<u>Macular Degeneration</u>
☐No One ☐Parents ☐Siblings ☐Grandparents ☐Other: _____
<u>Retinal Detachment</u>
☐No One ☐Parents ☐Siblings ☐Grandparents ☐Other: _____
<u>Glaucoma</u>
☐No One ☐Parents ☐Siblings ☐Grandparents ☐Other: _____
<u>Cataracts</u>
☐No One ☐Parents ☐Siblings ☐Grandparents ☐Other: _____
<u>Lazy/Crossed Eye</u>
☐No One ☐Parents ☐Siblings ☐Grandparents ☐Other: _____
<u>Blindness</u>
☐No One ☐Parents ☐Siblings ☐Grandparents ☐Other: _____