

# Welcome Thank you for choosing us

## **MEDICAL HISTORY**

#### **Personal Information**

Name	Middle Initial Last Name	Date
	City	Sate/ Zip/ Prov P.C Cell Phone
S\$#/SIN		Home Phone
Occupation Guardian (If applicable)	Gender	Marital Status

#### Insurance Information

Do you have vision i	nsurance? 🗖 No 🗖 Yes		
If yes, insurance car	rier	Name of primary insured?	
Relation	Birthdate	Last 4 digits of SSN of guarantor	
Do you have modice	al health insurance? 🗖 No 🗖 Yes		
Do you have medica			
If yes, insurance car	rier	Name of primary insured?	

Relation	Birthdate	Last 4 digits of SSN of guarantor
Medical History		
Do you have any allergies to medication?	🗖 No 🗖 Yes	If yes, explain

List medications you take (including aspirin, over-the-counter medications, and home remedies) and reason:

List all major injuries, surgeries, and/or hospitalization you have had: \_\_\_\_\_\_

List any of the following that you have had - crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye infury:

Are you pregnant and/or nursing?	<b>N</b> o	🗖 Yes	
Do you wear glasses?	🗖 No	🗖 Yes	If yes, how old is your present pair of lenses?
Do you wear contact lenses?	🗖 No	🗖 Yes	If yes, how old is your present pair of lenses?
Type of contact lenses?	🗖 No	🗖 Yes	Brand if known
Are you interested 'n REFRACTIV	/E SURGE	ERY 🗖 No	Yes

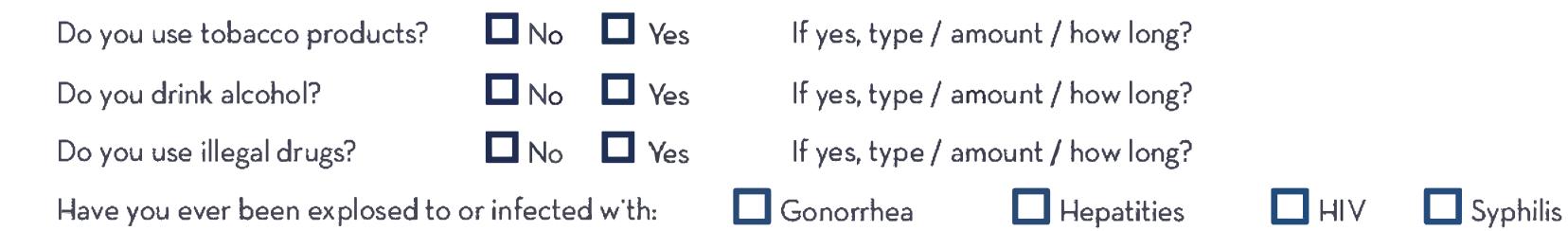
Social History This information is kept strictly confidential. however, you may discuss this portion directly with the doctor if you prefer.

Yes, I prefer to discuss my social history information directly with the doctor.

Do you drive? 🔲 No 🔲 Yes If yes, do you have visual difficulty when driving?



If yes, please describe



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# **MEDICAL HISTORY (Cont.)**

## Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Ves
Blindness		
Cataracts		
Crossed Eyes		
Glaucoma		
Macular Degeneration		
Retinal Detachment/Disease		
Arthritis		
Cancer		
Diabetes		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Lupus		
Thyroid Disease		

Relationsihp

Other

### **Review of Systems**

Do you currently , or have you ever had, any problems in the following areas:

	No	Yes	?		No	Yes	2		No	Yes	?
Constitutional				Ear, Nose, Mouth, Throa	t			Lymphatic/Heatologic			
Fever, Weight Loss/Gain				Allergies/Hay Fever				Anemia			
Integumentary				Sinus Congestion				Bleeding Problems			
Skin				Runny Nose				Allergic/Immunologic			
Neurological				Post-Nasal Drip				Psychiatric			
Headaches				Chronic Cough				Endocrine			
Migraines				Dry Throat/Mouth				Thyroid/Other Glands			
Seizures				Respiratory				Gaststro Intestinal			
Eyes				Asthma				Chronic Diarrhea			
Loss of Vision				<b>Chronic Bronchitis</b>				Genitourinary			
Blurred Vision				Emphysema				Genitals/Kidney/Bladder			
Distored vision/Halos				Vascular/Cardiovascular							
Loss of Side Vision				Diabetes							
Double Vision				Heart Pain							
Dryness				High Blood Pressure							
Mucous Discharge				Vascular Disease							
Redness				<b>Bones/Joints/Muscles</b>							
Sandy or Gritty Feeling				<b>Rheumatoid Arthritis</b>							
Itching				Muscle Pain							
Burning				Joint Pain							
Foreign Body Sensation											

## Excess tearing/Watering

#### If you answered yes to any of the above, or have a condition not listed, please explain and list medications.

Doctor's Signature:	Date				

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