

LAST NAME: _____ FIRST NAME: _____

SEX: _____ DOB: _____ ACCT #: _____

PATIENT HISTORY

ALLERGIES	Do you have any allergies to the following?						<input type="checkbox"/> Allergies on Front	
	Yes		No		List		Attention Information	
	Medications	<input type="checkbox"/>	<input type="checkbox"/>		Food	<input type="checkbox"/>	<input type="checkbox"/>	Name
Environmental/ Seasonal	<input type="checkbox"/>	<input type="checkbox"/>		Latex	<input type="checkbox"/>	<input type="checkbox"/>	Relationship	

EYE	Have you ever been diagnosed with the following?							
	Yes		No		Yes		No	
	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Ocular Herpes	<input type="checkbox"/>	<input type="checkbox"/>		
	Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	Ocular Trauma	<input type="checkbox"/>	<input type="checkbox"/>		
	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>		
	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>		
Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had any eye surgeries? If so, please describe. <input type="checkbox"/> Yes <input type="checkbox"/> No								

MEDICAL	Have you ever been diagnosed with the following?							
	Yes		No		Yes		No	
	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Lupus	<input type="checkbox"/>	<input type="checkbox"/>		
	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Type I or II Date Diagnosed	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Migraine/Headache	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
	CVA/Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Lung	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney/Intestinal	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No Date Started _____	Anesthetic Reaction	<input type="checkbox"/>	<input type="checkbox"/>		
Are you pregnant or nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Were you a premature baby? <input type="checkbox"/> Yes <input type="checkbox"/> No birth weight _____ term of pregnancy _____								
List any other major illnesses or hereditary problems?								

OTHER	Have you ever been diagnosed with the following?							
	Yes		No		Yes		No	
	AIDS/HIV/STDs	<input type="checkbox"/>	<input type="checkbox"/>	Date Diagnosed	TB	<input type="checkbox"/>	<input type="checkbox"/>	Date Diagnosed
Hepatitis A, B, C	<input type="checkbox"/>	<input type="checkbox"/>						

Who is treating you for this problem?

Do you have a DNR order in place? Yes No **If yes, do we have a copy on file?** Yes No

SOCIAL	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit Date _____	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you take recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Marital Status: Single Married Divorced Widowed	What is your occupation?

OPTICAL	Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you spend a lot of time outdoors? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No brand _____	Are you sensitive to light or experience glare? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you use a computer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have difficulty focusing? <input type="checkbox"/> Yes <input type="checkbox"/> No

DR	Who is your family doctor?	
	Name	Last Tetanus Shot (VSP)

FAMILY HISTORY

EYE	Have any members of your BLOOD relatives been diagnosed with any of the following?							
	Yes		No		Yes		No	
	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Relationship	Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>	Relationship
	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>		Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	
	Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>		Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	
	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		Lazy/Crossed Eye	<input type="checkbox"/>	<input type="checkbox"/>	
MEDICAL	Arthritis/Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Type _____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
	Cancer	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
	C.V.A./Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>					
List any other major illnesses or hereditary problems?								

PATIENT SIGNATURE _____ DATE _____

MD/TECHNICIAN _____ DATE _____

MUNSTER EYE CARE ASSOCIATES, P.C.

