**Patient Medical & Eye History**

Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_Last 4 of SS#\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_Gender: M\_\_\_\_\_F\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have You Been Seen at This Location Before? Y\_\_\_\_ N\_\_\_\_How Did You Hear About Us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have You Been Seen by Dr. Devine Previously? Yes\_\_\_@Sears/Lenscrafters No\_\_\_\_\_

Last Eye Exam Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age of Present Glasses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Medical Exam Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Any Medications You Are Currently Taking\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Any Drug or Other Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contacts?\_\_\_\_\_\_\_\_\_\_\_Are you interesting in trying contacts?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary reason for today’s visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems: Please check conditions that apply to you or your family.**

**EYE Yes No Family ENDOCRINE Yes No Family**

Flashes/Floaters \_\_\_ \_\_\_ \_\_\_ Thyroid Disease \_\_\_ \_\_\_ \_\_\_

 Glaucoma \_\_\_ \_\_\_ \_\_\_ Adrenal Problem \_\_\_ \_\_\_ \_\_\_

 Macular Degeneration \_\_\_ \_\_\_ \_\_\_

 Cataracts \_\_\_ \_\_\_ \_\_\_

 Retinal Disease/Defect \_\_\_ \_\_\_ \_\_\_ **PSYCHIATRIC**

 Lazy Eye/Amblyopia \_\_\_ \_\_\_ \_\_\_ Anxiety \_\_\_ \_\_\_ \_\_\_

 Dry Eye \_\_\_ \_\_\_ \_\_\_ Depression \_\_\_ \_\_\_ \_\_\_

**OTHER**

Hypertension \_\_\_ \_\_\_ \_\_\_

Diabetes \_\_\_ \_\_\_ \_\_\_ Cancer \_\_\_ \_\_\_ \_\_\_

Heart Disease \_\_\_ \_\_\_ \_\_\_ Stroke \_\_\_ \_\_\_ \_\_\_

Asthma/Breathing Problems \_\_\_ \_\_\_ \_\_\_ Explanations :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rheumatoid Arthritis \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you (currently or ever) experienced any of the following conditions? Please check if yes**:

\_\_\_Anemia/Bleeding Problems \_\_\_Lupus \_\_\_Eye Infections

\_\_\_Ankylosing Spondylitis \_\_\_Multiple Sclerosis \_\_\_Double Vision

\_\_\_Epilepsy \_\_\_Weight Loss/Gain \_\_\_Distorted Vision/Halos

\_\_\_Headaches \_\_\_Fever /Chills \_\_\_Eye Mucous/Discharge

\_\_\_Herpes Simplex/Cold Sores \_\_\_Bladder/Kidney/Urinary Ds. \_\_\_Eye Redness

\_\_\_Sjogren’s Syndrome \_\_\_Diarrhea/Constipation \_\_\_Eye Itching/Burning

\_\_\_STDs/Chlamydia/Gonorrhea \_\_\_Allergies/Hay Fever \_\_\_Eye Pain/Soreness

\_\_\_Tumor \_\_\_Sinus Problems \_\_\_Excess Tearing

\_\_\_Joint Pain \_\_\_Skin Problems \_\_\_Glare/Light Sensitivity

\_\_\_Eye Injury or Surgeries? If so, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Other? Please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke or use tobacco products? Yes \_\_\_\_No \_\_\_ Previous User\_\_\_\_ Use Caffeine? Yes\_\_\_ No\_\_\_

Are you pregnant or breastfeeding/nursing? Yes\_\_\_\_ No\_\_\_\_ Do you use alcohol? Yes\_\_\_ No\_\_\_