EYE CARE ASSOCIATES

Woodruff 715-356-2262 or Toll Free 1-800-441-0717
Eagle River 715-479-9390 Park Falls 715-762-2300
www.icareiwear.com

CONFIDENTIAL PATIENT MEDICAL HISTORY

Please print or write as clearly as possible.

Office Use Only
Date:_______________
Pachy OD:__________
Pachy OS:___________

NAME______________________________________

DATE OF BIRTH____________________________

FAMILY PHYSICIAN________________________

EMAIL______________________________________

CURRENT EYE PROBLEMS ☐ No Changes

Diabetes	__Y	__N
Glaucoma	__Y	__N
Macular Degeneration	__Y	__N
Lazy Eye	__Y	__N
Vision Loss/Blindness	__Y	__N
Cataracts	__Y	__N
Retinal Problems	__Y	__N

PAST EYE HISTORY ☐ No Changes

Surgery (describe) ________________________________
____
Laser (describe) ________________________________
____
Trauma (describe) ________________________________

CURRENT MEDICAL PROBLEMS ☐ No Changes

Diabetes	__Y	__N
High Blood Pressure	__Y	__N
Heart Disease	__Y	__N
Asthma	__Y	__N
Difficulty Breathing	__Y	__N
Thyroid Disease	__Y	__N
Anemia	__Y	__N
Migraine Headaches	__Y	__N
Cancer	__Y	__N
TB	__Y	__N
Stroke	__Y	__N

CURRENT MEDICATIONS/VITAMINS (INCLUDING ASPIRIN)

List all & include milligrams ☐ See List

____
____
____
____
____
____

PAST SURGERIES & OTHER MEDICAL PROBLEMS ☐ No Changes

____
____
____
____
____
____

ALLERGIES TO MEDICATIONS ☐ No Changes

____
____
____
____

FAMILY HISTORY ☐ No Changes

			If yes, who?
Macular Degeneration	__Y	__N	____________
Diabetes	__Y	__N	____________
Glaucoma	__Y	__N	____________
Visual Loss/Blindness	__Y	__N	____________
Cataracts	__Y	__N	____________
Malignant Hyperthermia	__Y	__N	____________
Cancer	__Y	__N	____________
High Blood Pressure	__Y	__N	____________
Heart	__Y	__N	____________
Stroke	__Y	__N	____________

SOCIAL HISTORY ☐ No Changes

			If yes, how much?
Do you smoke?	__Y	__N	____________
Do you drink alcohol?	__Y	__N	____________

FOR OFFICE USE ONLY

DR.______________________ DATE______________
DR.______________________ DATE______________
DR.______________________ DATE______________
DR.______________________ DATE______________