EYE CARE ASSOCIATES

CONFIDENTIAL PATIENT MEDICAL HISTORY

Please print or write as clearly as possible.

Office Use Only

Pachy OD:_____

Pachy OS:_____

NAME _____

DATE OF BIRTH _____

FAMILY PHYSICIAN _____

PHARMACY _____

CURRENT EYE PROBLEMS

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

Surgery (describe) _____

_____

Laser (describe) _____

_____

Trauma (describe) _____

_____

CURRENT MEDICAL PROBLEMS

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
AIDS	Y	N
MRSA	Y	N
Hepatitis	Y	N

PAST SURGERIES & OTHER MEDICAL PROBLEMS

_____

_____

_____

CURRENT MEDICATIONS/VITAMINS INCLUDING ASPIRIN _____**See List**

List all & include # of milligrams prescribed

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES TO MEDICATIONS

_____

_____

_____

_____

FAMILY HISTORY

			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

			If yes, how much?
Do you smoke?	Y	N	
Do you drink alcohol?	Y	N	

Occupation _____

Hobbies _____

For office use only

Dr. _____ Date:_____

Dr. _____ Date:_____

Dr. _____ Date:_____