O.M._____

Initials:_____

PLEASE FILL OUT COMPLETELY

MEDICAL HISTORY

Date_____/_____/ _____

Last Name_____ First Name_____ ❒ M ❒ F

Address _____ Phone _____

City_____ State_____ Zip _____ Cell Number_____

Birthdate _____/_____/_____ Age_____ Occupation _____

Guardian (if applicable)_____ Last Eye Exam _____/_____/ _____

Do you have vision insurance? ❒ No ❒ Yes If yes, insurance carrier_____

Name of Member_____ Member's Social Security # _____

Date of Birth of Member_____

Do you have health insurance? ❒ No ❒ Yes If yes, insurance carrier_____

Do you have medicare? ❒ No ❒ Yes E-Mail _____

Primary Care Doctor_____ Address:_____

Doctor's Telephone # _____ City/Zip Code _____

Referred by _____

Signature _____

Medical History

Do you have any allergies to medication? ❒ No ❒ Yes If yes, explain_____

_____

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

_____

_____

_____

List all major injuries, surgeries, and/or hospitalizations 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 injury _____

Are you pregnant and/or nursing? ❒ No ❒ 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: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ No ❒ Yes

What brand of contact lenses do you wear? _____

How often do you dispose of your contact lenses? _____ Are are you interested in contacts? ❒ No ❒ Yes

Family History

Please note any family history for the following conditions:

Disease/Condition	Self	Relative	None	Disease/Condition	Self	Relative	None
Blindness	❒	❒	❒	Diabetes	❒	❒	❒
Cataract	❒	❒	❒	Heart Disease	❒	❒	❒
Crossed Eyes	❒	❒	❒	High Blood Pressure	❒	❒	❒
Glaucoma	❒	❒	❒	Cancer	❒	❒	❒
Macular Degeneration	❒	❒	❒	Kidney Disease	❒	❒	❒
Retinal Detachment/Disease	❒	❒	❒	Lupus	❒	❒	❒
Arthritis	❒	❒	❒	Other	❒	❒	❒

_____

_____

— OVER —

Social History – This information is kept strictly confidential. However, you may discuss this portion 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? ❒ No ❒ Yes If yes, please describe:

_____

Do you use tobacco products? ❒ No ❒ Yes If yes, type/amount/how long _____

Do you drink alcohol? ❒ No ❒ Yes If yes, type/amount/how long _____

Do you use illegal drugs? ❒ No ❒ Yes If yes, type/amount/how long _____

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis ❒ None

Review of Systems

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

	Yes
Constitutional	
Fever, Weight Loss/Gain	❒
Integumentary	
Skin	❒
Neurological	
Headaches	❒
Migraines	❒
Seizures	❒
Eyes	
Loss of Vision	❒
Blurred Vision	❒
Distorted Vision/Halos	❒
Loss of Side Vision	❒
Double Vision	❒
Dryness	❒
Mucous Discharge	❒
Redness	❒
Sandy or Gritty Feeling	❒
Itching	❒
Burning	❒
Foreign Body Sensation	❒
Excess Tearing/Watering	❒
Glare/Light Sensitivity	❒
Eye Pain or Soreness	❒
Chronic Infection of Eye or Lid	❒
Stye or Chalazion	❒
Flashes/Floaters in Vision	❒
Tired Eyes	❒
Endocrine	
Thyroid/Other Glands	❒

	Yes
Ear, Nose, Mouth, Throat	
Allergies/Hay Fever	❒
Sinus Congestion	❒
Runny Nose	❒
Post-Nasal Drip	❒
Chronic Cough	❒
Dry Throat/Mouth	❒
Respiratory	
Asthma	❒
Chronic Bronchitis	❒
Emphysema	❒
Vascular/Cardiovascular	
Diabetes	❒
Heart Pain	❒
High Blood Pressure	❒
Vascular Disease	❒
Gastrointestinal	
Chronic Diarrhea	❒
Chronic Constipation	❒
Genitourinary	
Genitals/Kidney/Bladder	❒
Bones/Joints/Muscle	
Rheumatoid Arthritis	❒
Muscle Pain	❒
Joint Pain	❒
Lymphatic/Hematologic	
Anemia	❒
Bleeding Problems	❒
Allergic/Immunologic	❒
Psychiatric	❒

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

_____

_____

_____

_____

_____

Doctor's Signature _____ Date_____/_____/ _____

❒ Angelica Perez, O.D. ❒ Patricia Perez Vorona, O.D.