mcphersonfamilyeyecare

Patient Medical History Form

(Please be sure to bring your insurance cards, eyeglasses and contact lenses)

Patient Name: _____ DOB: _____

MEDICAL HISTORY

List any medications you are currently taking, including over the counter medications and herbal supplements:

_____

_____

List any allergies & your reaction: _____

Name of Family Doctor: _____ Date of last medical exam: _____

Previous Eye Doctor:_____ Date of last eye exam: _____

Have you had any surgeries, including eye surgery? If yes, please list type and approximate date:

_____

Have you had any major injuries, or hospitalizations? Y / N_____

Are you currently pregnant or nursing? Y / N

Do you smoke? Y / N If yes, when did you start? _____ How many packs per day? _____

If no, are you a former smoker?_____

Do you consume alcohol? Y / N If yes, how much? _____

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply & list family member):

☐ Diabetes _____ ☐ High blood pressure _____

☐ Heart Disease _____ ☐ Cancer--type: _____

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply & list):

☐ Strabismus _____ ☐ Amblyopia (lazy eye) _____ ☐ Retinal Detachment _____

☐ Glaucoma _____ ☐ Macular Degeneration _____

Do you wear glasses? Yes / No

Do you wear contact lenses? Yes / No

Would you like to try contact lenses? Yes / No

REVIEW OF SYSTEMS:

Do you currently, or have you ever had any problems in the following areas? Please *circle* the condition(s) that you have.

To indicate a past problem, write a "P" next to the condition. All of these may affect the health of your eyes.

Ocular/Eye Problems Glaucoma Amblyopia (Lazy Eye) Cataract Inflammatory Disease Dry Eye Retinal problems Macular Degeneration Strabismus (Eye Turn)	**Constitutional Problems** Fever Weight Loss/Gain Cancer Fatigue Developmental Disability	**Ear/Nose/Mouth/Throat Problems** Allergies/Hay Fever Sinus Congestion Laryngitis Dry Mouth Hearing Loss Sinusitis
Neurological Problems Headaches Cerebral Palsy Multiple Sclerosis Tumor Epilepsy	**Psychiatric Problems** Depression Anxiety	**Cardiovascular Problems** Vascular Disease Stroke Congestive Heart Failure Heart Disease High Blood Pressure High Cholesterol
Respiratory Problems Emphysema Bronchitis COPD Asthma	**Gastrointestinal Problems** Colitis Crohn's disease Ulcer Irritable Bowel Syndrome	**Genitourinary Problems** Prostate Disease/Cancer STD Kidney Disease
Musculoskeletal Problems Ankylosing Spondylitis Fibromyalgia Muscular Dystrophy Osteoarthritis	**Skin Problems** Rosacea Psoriasis Eczema	**Endocrine Problems** Insulin Dependent Diabetes (Type I) Non-Insulin Diabetes (Type II) Hormonal Dysfunction Thyroid Dysfunction (Hypo/Hyper)
Blood/Lymph Problems Anemia Large volume blood loss	**Allergy/Immunologic Problems** Rheumatoid Arthritis Lupus Allergies: Drug/ Environmental	**Other: Please list**

Consent for Treatment: I hereby authorize McPherson Family Eye Care to administer diagnostic and medical procedures as may be necessary for proper health care.

Consent for E-Prescribing: I hereby authorize McPherson Family Eye care to send any prescriptions for medications to my pharmacy by way of e-prescribing.

_____ _____

Printed Name of Patient Date

_____

Signature