# Family Eye Care Center Patient Medical History

NOTE: PLEASE DO NOT LEAVE ANY AREAS BLANK. IF A QUESTIONS DOES NOT PURTAIN TO YOU PLEASE PUT **N/A** (Not Applicable)

DATE_____

PATIENT NAME _____ NICK NAME_____

MEDICAL HISTORY (ANY PAST/ CURRENT MEDICAL CONDITIONS) _____

_____

SURGICAL HISTORY (SURGERY, INCLUDING COMPLICATIONS, TRAUMA) _____

_____

CURRENT MEDICATIONS AND DOSAGE _____

_____

_____

MEDICATION ALLERGIES/ REACTIONS _____

_____

LAST WELL VISION EXAMINATION? DR._____ WHERE_____WHEN? _____

PRIMARY PHYSICIAN _____ PHONE _____

FAMILY MEDICAL HISTORY (ESPECUALLY PARENTS AND SIBLINGS) _____

_____

EYE SURGERIES _____

FAMILY EYE HISTORY (GLASSES, CONTACTS, SURGERYS) _____

_____

DO YOU CURRENTLY SMOKE, USE ALCOHOL OR DRUGS?

**DO YOU…**

**CURRENTLY WEAR GLASSES** Y N

**WEAR PROGRESSIVE LENSES** Y N

**ANY CONCERNS WITH GLASSES** Y N

**DO YOU HAVE A BACKUP PAIR OF GLASSES** Y N

**CONCERNS WITH GLARE?** Y N **SCRATCHES?** Y N **WEAR SUNGLASSES** Y N

**ARE YOU INTERESTED IN KNOWING ABOUT CONTACT LENSES?** Y N

**CURRENTLY WEAR CONTACT LENSES** Y N **MONO VISION** Y N **BIFOCAL** Y N

**REPLACEMENT FREQUENCY?**

**NEW PATIENTS ONLY** TO WHOM MAY WE THANK FOR REFERRING YOU TO FAMILY EYE CARE CENTER?

_____

IF NOT REFERRED, HOW DID YOU FIND OUT ABOUT FAMILY EYE CARE CENTER

SIGNATURE X DATE

FORM UPDATED 11-21