



International Eyecare Center

Date \_\_\_\_\_
Date Updated \_\_\_\_\_
Date Updated \_\_\_\_\_

Patient Name \_\_\_\_\_

Medical History

Last Eye Exam \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_

Last Medical Exam \_\_\_\_\_

Do you have any allergies to medications? [ ] no [ ] yes If yes, please explain: \_\_\_\_\_

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

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, 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 currently wear sunglasses with ultraviolet protection? [ ] no [ ] yes

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

Family History Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions.

Table with columns: DISEASE/CONDITION, NO, YES, ?, RELATIONSHIP TO YOU. Rows include Blindness, Cataract, Crossed Eyes, Glaucoma, Macular Degeneration, Retinal Detachment/Disease, Arthritis, Cancer, Diabetes, Heart Disease, High Blood Pressure, Other.

Social History: To be compliant with Medicare and other Insurance Companies, we are required to ask this information.

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

[ ] Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? [ ] No [ ] Yes If yes, do you have visual difficulty when driving? [ ] No [ ] Yes

Do you use tobacco products? [ ] No [ ] Yes [ ] Occasionally

Do you drink alcohol? [ ] No [ ] Yes [ ] Occasionally

Do you use illegal drugs? [ ] No [ ] Yes [ ] Occasionally

Have you ever been exposed to or infected with: [ ] Gonorrhea [ ] Hepatitis [ ] HIV [ ] Syphilis

REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas?

Table with columns: SYSTEM, NO, YES, ?. Rows include EYES (Loss of Vision, Blurred Vision, etc.), EARS, NOSE, THROAT (Allergies/Hay Fever, Sinus Congestion), RESPIRATORY (Asthma), VASCULAR (Diabetes, Heart Pain, High Blood Pressure, Vascular Disease), BONES/JOINTS/MUSCLES (Rheumatoid Arthritis), LYMPHATIC/HEMATOLOGIC (Anemia, Bleeding Problems), NEUROLOGICAL (Headaches, Migraines, Seizures).

Academic History (For children 18 and under)

Indicate any of these symptoms when reading:

poor comprehension [ ] poor memory [ ] fatigue [ ] works slowly [ ] seems too hard [ ]
avoidance [ ] eye strain [ ] loses place [ ] can't stay on task [ ] headaches during or after [ ]

Is the child achieving at expected levels in school? [ ] no [ ] yes