International Eyecare Center

Date ________________
Date Updated ________________
Date Updated ________________

Patient Name ______________________________________

Medical History

Last Eye Exam ________________
Last Medical Exam ________________

Name of Medical Doctor: ______________________________

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.

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
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?

SYSTEM	NO	YES	?
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	❑	❑	❑
Excess Tearing/Watering	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of eye or lid	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes/Floaters in vision	❑	❑	❑
Tired Eyes	❑	❑	❑

SYSTEM	NO	YES	?
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