Greater Thumb Eyecare History Form

Name:		
Address:		
Home Phone:	Cell Phone:	
Social Security Number:	Date of Birth:	Birth State:
Occupation/Employer	Email:	
Last Eye Exam:	Where:	
Reason For Today's Visit:		
Current Medical PCP:	Date of Last Visit:	
Do you wear glasses?	Do you wear contact?	Do you want contacts?
Do you smoke?	Have you ever smoked?	
Do you drink alcohol?	If Yes: Daily Social	
Any Drug Use?	Any Known Drug Allergies?	
Pharmacy That You Use:	Language/Race:	
Are you Pregnant or Nursing?	Hobbies:	

HEALTH HISTORY

Ocular:	Y	N	Comments	**Do you Experience:**	Y	N		Y	N
Eye Surgery				Burning or Gritty			Blurry to near		
Cataracts				Watering Eyes			Light Flashes		
Glaucoma				Dryness			Floaters/Spots		
Eye turn/lazy eye				Itching			Double Vision		
Family History:				Sensitivity to light			Redness		
Diabetes				Headaches			Discharge		
Glaucoma				Blurry Distance vision			Soreness or Pain		
Macular Degen									
Blindness									
Eye turn/lazy eye									

MEDICAL HISTORY:

Cardiovascular (heart, high blood pressure, high cholesterol):
Ear, Nose, Mouth, Throat:
Respiratory (asthma, copd):
Gastrointestinal (hernia, reflux):
Genitourinary (bladder, kidney):
Musculoskeletal (arthritis):
Skin:
Neurological (migraines, stroke, seizures):
Psychiatric (depression, bipolar, anxiety):
Endocrine (thyroid, diabetes – list last blood sugar level and/or A1C):
Hematologic (blood disorders):
Allergies, Immunologic (lupus, autoimmune):
CURRENT MEDS AND DOSAGE: