

## Greater Thumb Eyecare History Form

Name:			SSN:		
Date of birth:			State of birth:		
M	F	Gender	M	F	How do you Identify?
Address:					
If minor, accompanied by:			Relationship to minor:		
Y	N	Sensory issues:			
Home Phone:			Cell Phone:		
Email:			Occupation/Employer:		
Pharmacy that you prefer:					
Current Medical Dr.:			Last eye exam:		
Date of exam:			Date of exam:		
Do you wear glasses? Y N			Do you want contacts? Y N		
Do you wear contacts, if yes, what kind?					
<b>Ocular History:</b>			<b>Family History:</b>		
Y	N	Eye Surgery	Y	N	Diabetes
Y	N	Cataracts	Y	N	Glaucoma
Y	N	Macular Degeneration	Y	N	Blindness
Y	N	Eye turn/lazy eye	Y	N	Eye turn/lazy eye
Y	N	Do you drink alcohol? If yes, daily / social	Y	N	Do you smoke?
Y	N	Any recreational drug use:	Y	N	Have you ever smoked?
<b>Medical History:</b>					
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 and/or A1C):					
Hematologic (blood disorders):					
Allergies, Immunologic (lupus, autoimmune):					
Reason for today's visit:					
Y	N	Blurry Distance vision	Y	N	Burning or Gritty
Y	N	Blurry Near vision	Y	N	Itching
Y	N	Headaches	Y	N	Sensitivity to light
Y	N	Watering eyes	Y	N	Light flashes
Y	N	Dryness	Y	N	Floaters / Spots
Y	N	Redness	Y	N	Discharge
Y	N	Double vision	Y	N	Soreness or Pain
Any known <b>Drug Allergies</b> ?					
Current Medications and Dosage (if you have a printed list, please have it available for the technician - if you need more room, please use back):					
1			6		
2			7		
3			8		
4			9		
5			10		