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.:	Date of last eye exam:
Date of exam:	Preformed by:
Do you wear glasses? **Y N**	Do you want contacts? **Y N**
Do you currently wear contacts, **Y N** If yes, what kind?	

		Ocular History:			**Family History:**
Y	N	Eye Surgery	Y	N	Diabetes
Y	N	Cataracts	Y	N	Blindness
Y	N	Glaucoma	Y	N	Glaucoma
Y	N	Macular Degeneration	Y	N	Macular Degeneration
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?

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 and/or A1C):
Hematologic (blood disorders):
Allergies, Immunologic (lupus, autoimmune):
Reproductive: Are you currently pregnant? Y N If Yes, due date:

Reason for today's visit:

Y	N	Blurry Distance vison	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

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

Any known **Drug Allergies**?