CONFIDENTIAL MEDICAL HISTORY

Name_____Nick Name _____Date_____

Address_____City_____State_____Zip_____Age_____

Home phone_____Cell phone_____Birthdate_____

Employer_____Wk Phone_____SS#_____

Name of Parent or Spouse_____Type of Vision Insurance_____REFERRED BY_____

Name of MEDICAL HEALTH INS _____ Name of Primary member of plan_____

May we contact you via Email or Text? Yes No Email:

PATIENT PAST MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY

Allergies Asthma Arthritis Cancer COPD Crohn's

Diabetes Headaches Lupus Kidney / Thyroid / Heart Disease

Hypertension IBS Seizures Stroke Sarcoid

Injuries/ Surgeries/Hospital

Primary Care Dr & Phone:

Last Eye Exam Pregnant / Nursing Y / N

MEDICATIONS	ALLERGIES
	VITAMINS

REVIEW OF SYSTEMS: Do you ***CURRENTLY*** experience or have any of the following symptoms below? Please check all that apply:

EYES / VISION: Blurred Distorted Double Loss of vision
Redness Tearing Burning Glare Light Sensitive Itchy
Dry Gritty Flashes of light Tired Eyes Eye Strain
Mucus Discharge Chronic Infections Eye pain Floaters or Spots

GENERAL: Fever Fatigue Night Sweats Weight Loss / Gain

NEURO: Headache Migraine Numbness Dizzy Seizures Vertigo

ENT: Allergies Sinus Cough Dry Mouth Hearing Hay Fever

AUTO IMMUNE: RA Lupus Crohn's HIV

GI: Diarrhea Constipation Vomiting Ulcer Hernia

CARDIO / HEART: High BP Heart Disease Irregular beat

SKIN: Acne Rosecea Cancer Eczema Rash

PSYCH: Anxiety Depression Insomnia

ENDOCRINE: Diabetes Thyroid Adrenal

RESPIRATORY: Asthma Bronchitis COPD Sleep Apnea

REPO / URINARY: Kidney Problems Bladder Prostate Genitalia

MUSCLE / SKELETAL: Joint pain Muscle pain

BLOOD: Anemia High cholesterol Blood Clots Bleeding

PATIENT OCULAR HISTORY: Please check off all that apply: Allergic Reaction Blepharitis Loss of vision Cataracts / Surgery Glaucoma
Conjuntivitis (pink eye) Contact Dermatitis Double Vision Lazy Eye Eye exercises / Patching Floaters Flashes of Light
Hemorrhage Herpes, Iritis Eye Injury Keratoconus Macular Degeneration Retinal Detachment Stroke Retinal Tear

I HAVE or USE: Distance Glasses, Reading glasses, Bifocal Glasses, Computer Glasses. **Contact Lenses:** Disposable, Gas Permeable, Bifocals, Mono Vision

FAMILY HISTORY: M=Mother; F=Father; S=Sister; B= Brother; MGM=Maternal grandmother MGF= Maternal grandfather PGM= Paternal Grandmother PGF=Pat Grandfather

_____Arthritis _____Asthma _____Cancer _____Diabetes _____Headaches _____Heart Disease _____Hypertension _____Kidney Disease

_____Thyroid Disease _____Lupus or RA _____Cataracts ____GLAUCOMA _____ MACULAR DEG ____Crossed or Lazy eye _____RETINAL DETACH_____Blindness

SOCIAL HISTORY (to be in compliance w gov regulation) **Race:** Asian Black Hispanic Indian White **Height:** **Weight:**

Occupation: **Hobbies / Sports:**

Tobacco Use: Yes No Amount?

Alcohol Use: Yes No Social Monthly Weekly Daily

ACKNOWLEDGEMENT: I acknowledge that I have received, and / or read, and understand the policy of Skowron Eye Care Notice of Privacy Practices

Signature: Date: Reviewed by Dr. Date: