ESTACADA
EYECARE PC

MEDICAL HISTORY FORM

Name: _____ **DOB:** _____ **Date:** _____

Preferred Name: _____

Date of last physical: _____ **Primary Physician:** _____

List all major injuries, surgeries and/or hospitalizations: _____

_____

Are you on any medications? ☐ Yes ☐ No **If yes, which ones** _____

_____

Are you allergic to any medications? ☐ Yes ☐ No **If yes, which ones** _____

_____

Are you pregnant? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No **How often?** _____

Do you drink alcohol? ☐ Yes ☐ No **How often?** _____

EYE HISTORY

Have you experienced any of the following and/ or diagnoses?

Blurred Vision	☐ Yes ☐ No	Dryness	☐ Yes ☐ No	Itching	☐ Yes ☐ No
Burning	☐ Yes ☐ No	Eye Pain	☐ Yes ☐ No	Lazy Eye	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Flashes of light	☐ Yes ☐ No	Light Sensitivity	☐ Yes ☐ No
Crusting on Eyelid	☐ Yes ☐ No	Floating dark spots	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No
Decreased Vision	☐ Yes ☐ No	Foreign Body	☐ Yes ☐ No	Redness	☐ Yes ☐ No
Discharge	☐ Yes ☐ No	Sensation	☐ Yes ☐ No	Retinal Tear/Detachment	☐ Yes ☐ No
Double Vision	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No		
Drooping Eyelid	☐ Yes ☐ No	Halos	☐ Yes ☐ No	Sandy/gritty feeling	☐ Yes ☐ No

Past Eye Surgeries? ☐ Yes ☐ No Type _____ Date: _____

Past Eye Injuries? ☐ Yes ☐ No Type _____ Date: _____

Other _____

Do you wear glasses? ☐ Yes ☐ No **Do you wear contacts lenses?** ☐ Yes ☐ No

FAMILY OCULAR HISTORY

RELATIVE	AGE	EYE DISEASE
Mother	_____	_____
Father	_____	_____

MEDICAL HISTORY

Are you currently experiencing or being treated for any of the following?

	YES	NO	FAMILY
• Arthritis:	☐	☐	☐
• Diabetes:	☐	☐	☐
• High Blood Pressure:	☐	☐	☐
• Heart Disease:	☐	☐	☐
• Stroke:	☐	☐	☐
• Cardiovascular:	☐	☐	☐
• Endocrine:	☐	☐	☐
• Ear/Nose/Throat:	☐	☐	☐
• Sudden weight gain or loss:	☐	☐	☐
• Respiratory:	☐	☐	☐
• Gastrointestinal:	☐	☐	☐
• Urinary:	☐	☐	☐
• Integumentary:	☐	☐	☐
• Hematologic/Lymphatic:	☐	☐	☐
• Musculoskeletal:	☐	☐	☐
• Neurological:	☐	☐	☐
• Psychiatric:	☐	☐	☐
• Allergic/Immunologic:	☐	☐	☐

- Other: _____

Patient's Signature: _____ Date: _____

Patient's Legal Representative _____ Date: _____