Medical History:

EYEDENTITY eyecare
2176 Hillsboro Road, Suite 100
Franklin, TN 37069
615.791.7030

Name: ____ Today's Date _____________________
Date of Birth:_____/_____/_____ SS#_____/_____/_____
Last Eye Doctor: ______________________________________ Last Eye Exam _________/______ (Mon & Yr)
Current Medical Doctor:________________________________ Last Medical Exam _________/______ (Mon & Yr)

Medical History

Do you have any allergies to medications? Yes No
If yes, explain: ____
List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies): ____
List all major injuries, surgeries and/or hospitalizations you have had:
list- ____

Check any of the following that you have had:

Check one Reading Difficulty Crossed Eyes Lazy Eye Glaucoma Retinal Disease Cataracts Eye Injury
Are you pregnant and/ or nursing? Yes No
Do you wear glasses? Yes No If yes, how old is you present pair of glasses?______
How many pair of glasses do you currently use?______
Do you wear contact lenses? Yes No If yes, how old is your present pair of contacts?______
Type of contact lenses? Rigid Soft Extended Wear Other Are they comfortable? Yes No
Have you had refractive surgery? Yes No
At work: Do you perform fine or close-up work? Yes No Is safety protection a concern at work? Yes No
Are you outdoor all or part of the time? Yes No
Do you have trouble reading signs when driving at night? Yes No
Are you bothered by the glare from: Overhead lighting? Yes No
Oncoming headlights at night? Yes No
A computer screen? Yes No
Are you sensitive in bright sunlight? Yes No
What hobbies or recreational sports do you enjoy? ____

Family History....

Have any of your relatives, living or deceased, had any of these conditions? Relationship To You
Ocular Disease/Condition Yes No Not Sure ______________________________
Blindness Yes No Not Sure ______________________________
Cataract Yes No Not Sure ______________________________
Crossed Eyes Yes No Not Sure ______________________________
Glaucoma Yes No Not Sure ______________________________
Macular Degeneration Yes No Not Sure ______________________________
Retinal Detachment/ Disease Yes No Not Sure ______________________________
Systemic Disease / Condition
Arthritis Yes No Not Sure ______________________________
Cancer Yes No Not Sure ______________________________
Diabetes Yes No Not Sure ______________________________
Heart Disease Yes No Not Sure ______________________________
High Blood Pressure Yes No Not Sure ______________________________
HIV/AIDS Yes No Not Sure ______________________________
Lupus Yes No Not Sure ______________________________
Thyroid Disease Yes No Not Sure ______________________________
Other____

Social History:

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This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor.

(Check box) Do you drive? Yes No

If yes, do you have visual difficulty when driving? Yes No If yes, please describe: ____________________

____

Do you use tobacco products? Yes No If yes, type/amount/how long: ______________________________

Do you drink alcohol? Yes No If yes, type/amount/how long: ______________________________________

Do you use recreational drugs? Yes No If yes, type/amount/how long: _____________________________

Have you ever been exposed to or infected with: Gonorrhea Hepatitis Syphilis No, I have not.

Review of Systems:

Do you currently, or have you ever had any problems in the following areas:

System	Yes	No	Not Sure	System	Yes	No	Not Sure
Cancer	Yes	No	Not Sure	**Ears, Nose, Mouth, Throat**	Yes	No	Not Sure
Constitutional				Allergies/Hay Fever	Yes	No	Not Sure
Fever, Weight Loss/Gain	Yes	No	Not Sure	Sinus Congestion	Yes	No	Not Sure
Skin (Integumentary)	Yes	No	Not Sure	Runny Nose	Yes	No	Not Sure
Neurological				Post-Nasal Drip	Yes	No	Not Sure
Headaches	Yes	No	Not Sure	Chronic Cough	Yes	No	Not Sure
Migraines	Yes	No	Not Sure	Dry Throat/ Mouth	Yes	No	Not Sure
Seizures	Yes	No	Not Sure	**Respiratory**			
Eyes				Asthma	Yes	No	Not Sure
Loss of Vision	Yes	No	Not Sure	Chronic Bronchitis	Yes	No	Not Sure
Blurred Vision	Yes	No	Not Sure	Emphysema	Yes	No	Not Sure
Distorted Vision/Halos	Yes	No	Not Sure	**Vascular/Cardiovascular**			
Loss of Side Vision	Yes	No	Not Sure	Diabetes	Yes	No	Not Sure
Double Vision	Yes	No	Not Sure	Heart Pain	Yes	No	Not Sure
Dryness	Yes	No	Not Sure	High Blood Pressure	Yes	No	Not Sure
Mucous Discharge	Yes	No	Not Sure	Vascular Disease	Yes	No	Not Sure
Redness	Yes	No	Not Sure	Brain Injury/Stroke	Yes	No	Not Sure
Sandy or Gritty Feeling	Yes	No	Not Sure	**Gastrointestinal**			
Itching	Yes	No	Not Sure	Diarrhea	Yes	No	Not Sure
Burning	Yes	No	Not Sure	Constipation	Yes	No	Not Sure
Foreign Body Sensation	Yes	No	Not Sure	**Genitourinary**	Yes	No	Not Sure
Excess Tearing/ Watering	Yes	No	Not Sure	Genitals/Kidney/Bladder	Yes	No	Not Sure
Glare/Light Sensitivity	Yes	No	Not Sure	**Bones/Joints/Muscles**			
Eye Pain or Soreness	Yes	No	Not Sure	Rheumatoid Arthritis	Yes	No	Not Sure
Chronic Infection of Eye/ Lid	Yes	No	Not Sure	Muscle Pain	Yes	No	Not Sure
Sty of Chalazion	Yes	No	Not Sure	Joint Pain	Yes	No	Not Sure
Flashes/Floaters in Vision	Yes	No	Not Sure	**Lymphatic/Hematologic**			
Tired Eyes	Yes	No	Not Sure	Anemia	Yes	No	Not Sure
Endocrine	Yes	No	Not Sure	Bleeding Problems	Yes	No	Not Sure
Thyroid/Other Glands	Yes	No	Not Sure				
Psychiatric	Yes	No	Not Sure	**Allergic/Immunologic**	Yes	No	Not Sure

DO NOT WRITE BELOW THIS LINE (Doctor's Comments):

I have reviewed this history with the patient:

Doctor's Signature	Date