

EXACT EYE CARE - Medical History



Name _____ (Please Print) DOB _____ Gender: M / F

Are you covered by Medicaid / Medicare (circle) Age _____ Today's Date _____

We appreciate referrals, who may we thank for referring you to Exact Eye Care? _____

VISUAL SYMPTOMS (Please indicate any problems you are currently having with your current spectacles or contacts)

<input type="checkbox"/> Blur at distance (Driving)	<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Glare / Halos
<input type="checkbox"/> Blur at near (Reading)	<input type="checkbox"/> Red Eyes	<input type="checkbox"/> Burning Eyes	<input type="checkbox"/> Seeing Floaters
<input type="checkbox"/> Difficulty seeing at night	<input type="checkbox"/> Watery Eyes	<input type="checkbox"/> Headaches	<input type="checkbox"/> Seeing Flashes
<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Other

REVIEW OF SYSTEMS - do you have problems with any of the following (if yes, please circle or list)

Yes	No	<input type="checkbox"/> <input type="checkbox"/> Eyes -- Glaucoma / Cataract / Lazy Eye / Retina Disease / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Endocrine -- Diabetes / Thyroid Problems / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Cardiovascular -- High Blood Pressure / High Cholesterol / Heart Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Constitutional -- Fever / Weight Loss / Weight Gain / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Ear, Nose, Throat, Mouth -- Sinus Problems / Sore Throat / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Respiratory -- Cough / Asthma / Emphysema / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Gastrointestinal -- Diarrhea / Reflux / Pain / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Genitourinary -- Kidney Problems / Prostate Problems / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Integumentary -- Skin Dryness / Rosacea / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Musculoskeletal -- Arthritis / Joint Pain / Swollen Joints / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Neurological -- Numbness / Headaches / Nausea / Multiple Sclerosis / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Hematological/Lymphatic -- Blood Disorders / Leukemia / Anemia / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Allergic/Immunologic -- Hay Fever / Seasonal Allergies / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Psychiatric -- Depression / Anxiety / ADHD / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Others -- Cancer / _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Women -- Pregnant / Nursing / _____

PAST HISTORY - please list past injuries or surgeries:

MEDICATIONS - please list any medications you take

Family Physician Name: _____

Medication Allergies: _____

FAMILY HISTORY - Do your family members have any of the following

Yes	No	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	Yes	No	<input type="checkbox"/> <input type="checkbox"/> Diabetic Retinopathy	Yes	No	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Other

SOCIAL HISTORY

Yes No Occupation: _____

Do you have prescription sunglasses?

Do you have more than 1 pair of current eyeglasses?

Do you use a computer?

Are you interested in discussing / wearing contact lenses?

Are you interested in discussing LASIK?

Yes No Hobbies: _____

Do you smoke?

Do you drink alcohol?

Do you use drugs?

Dilation of the pupil is a common procedure used to better examine the inside of the eye. It allows us to detect and/or monitor conditions of the eye such as glaucoma and macular degeneration as well as diseases of the body such as diabetes and hypertension. Eyedrops used to dilate your pupils last 4 to 6 hours. Light sensitivity and blurred vision, especially at near, are common. There are few risks to this procedure.

Yes, perform a dilated exam No, I decline dilation today I want more information

Patient's Signature _____ **Date** _____

Reviewed On: date/initials _____