EXACT EYE CARE

Medical History

exacteyecare.com

Name: _____ Clinic Location: _____

(Please Print)

Date of Birth: _____

Gender: O Male OFemale

Age: _____

Today's Date: _____

Are you covered by: O Medicaid O Medicare

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

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

O Blur at distance (Driving)	O Itchy Eyes	O Eye Pain	O Glare / Halos
O Blur at near (Reading)	O Red Eyes	O Burning Eyes	O Seeing Floaters
ODifficulty seeing at night	O Watery Eyes	O Headaches	O Seeing Flashes
O Light Sensitivity	O Dry Eyes	O Double Vision	OOther

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

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

EXACT EYE CARE

Medical History

exacteyecare.com

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		Yes	No		Yes	No	
O	O	Glaucoma	O	O	Diabetic Retinopathy	O	O	Diabetes
O	O	Macular Degeneration	O	O	Retinal Detachment	O	O	High Blood Pressure
O	O	Cataracts	O	O	Blindness	O	O	Other

Yes	No	
O	O	Do you have prescription sunglasses?
O	O	Do youhave more than 1 pair of current eyeglasses?
O	O	Do you use a computer?
O	O	Are you interested in discussing / wearing contact lenses?
O	O	Are you interested in discussing LASIK?

SOCIAL HISTORY

Occupation: _____

Hobbies: _____

Yes	No	
O	O	Do you smoke?
O	O	Do you drink alcohol?
O	O	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 conditons of the eye such as glaucoma and macular degeneration as well as diseases of the body such as diabetes and hypertansion. Eye drops 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.

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

_____

Patient's Signature Date

Reviewed On: date/initials: _____