

MEDICAL HISTORY

ATHENS EYE CARE CENTER, P.C.

Name: _____ Date of Birth: _____

SSN: _____ Last Eye Exam: _____

Name of Medical Doctor: _____ Dr's Phone #: _____

Do you have any allergies to medications? Yes or 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:

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections or eye injury.

Are you pregnant and/or nursing? Yes or No

Do you wear glasses? Yes or No

If yes, how old is your pair of glasses? _____

Do you wear contact lenses? Yes or No

If yes, how old is your present pair? _____

Type of contact lenses (Circle One): Rigid Soft Extended Wear Other

Are they comfortable? Yes or No

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION

RELATIONSHIP TO YOU

Blindness Yes or No

Cataract Yes or No

Crossed Eyes Yes or No

Glaucoma Yes or No

Macular Degeneration Yes or No

Retinal Detachment/Disease Yes or No

Arthritis Yes or No

Cancer Yes or No

Diabetes Yes or No

Heart Disease Yes or No

High Blood Pressure Yes or No

Kidney Disease

Yes or No

Lupus

Yes or No

Thyroid Disease

Yes or No

Other

Yes or No

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

Do you drive? Yes or No

If yes, do you have difficulty when driving? Yes or No

If yes, please describe: _____

Do you use tobacco products? Yes or No

If yes, type/amount/how long? _____

Do you drink alcohol? Yes or No

If yes, type/amount/how long? _____

Do you use illegal drugs? Yes or No

If yes, type/amount/ how long? _____

Have you ever been exposed to or infected with (Circle any that apply):

Gonorrhea Hepatitis HIV Syphilis

REVIEW OF SYMPTOMS

Do you currently, or have you ever had any problems in the following areas?: (If Yes, please explain and list medications)

System

Explain/List Medications

Constitutional (fever/weight loss/gain)

Yes or No

Integumentary (skin)

Yes or No

Neurological

Headaches

Yes or No

Migraines

Yes or No

Seizures

Yes or No

EYES

Loss of Vision

Yes or No

Blurred Vision

Yes or No

Distorted Vision/Halos

Yes or No

Loss of Side Vision

Yes or No

Double Vision

Yes or No

Dryness

Yes or No

Mucous Discharge

Yes or No

Redness

Yes or No

Sandy or Gritty Feeling

Yes or No

Itching

Yes or No

Burning

Yes or No

Foreign Body Sensation

Yes or No

Excess Tearing/Watering

Yes or No

Glare/Light Sensitivity

Yes or No

Eye Pain or Soreness

Yes or No

Chronic Infection of Eye or Lid

Yes or No

Styes or Chalazion

Yes or No

Flashes/Floaters in Vision

Yes or No

Tired Eyes

Yes or No

EAR, NOSE, MOUTH, THROAT

Allergies/ Hay Fever

Yes or No

Sinus Congestion

Yes or No

Runny Nose

Yes or No

Post-Nasal Drip

Yes or No

Chronic Cough Yes or No

Dry Throat/ Mouth Yes or No

RESPIRATORY

Asthma Yes or No

Chronic Bronchitis Yes or No

Emphysema Yes or No

VASCULAR/ CARDIOVASCULAR

Diabetes Yes or No

Heart Pain Yes or No

High Blood Pressure Yes or No

Vascular Disease Yes or No

GASTROINTESTINAL

Diarrhea Yes or No

Constipation Yes or No

GENITOURINARY (genitals, kidney/bladder) Yes or No

System

Explain/List Medications

BONES/JOINTS MUSCLES

Rheumatoid Arthritis

Yes or No

Muscle Pain

Yes or No

Joint Pain

Yes or No

LYMPHATIC/ HEMATOLOGIC

Anemia

Yes or No

Bleeding Problems

Yes or No

ENDOCRINE (thyroid/other glands)

Yes or No

ALLERGIC/ IMMUNOLOGIC

Yes or No

PSYCHIATRIC

Yes or No
