Eudora Eye Care, P.A.

Patient History Form

Date: _____/_____/_____

□ Mr. □ Miss. □ Mrs. □ Ms. □ Dr.

Name: _____ MI _____ Phone: _____

Address: _____ _____ Work Phone: _____

City: _____ Zip: _____ Occupation: _____

Guardian (If applicable): _____

Birth Date: _____/_____ / _____ SSN: _____/_____ / _____

Name of Medical Doctor: _____ Doctor's Phone: (_____)_____-_____

Last Medical Exam:_____/_____ / _____

Name of previous Optometrist: _____ Last Eye Exam: _____/_____/_____

Insurance:

Vision:

Insurance Company: _____ Policy Number: _____

Name of Insurance Holder: _____ DOB: _____ /_____ / _____ SSN: _____

Employer: _____ Relationship: _____

Medical

Insurance Company: _____ Policy Number: _____

Name of Insurance Holder: _____ DOB: _____ /_____ / _____ SSN: _____

Employer: _____ Relationship: _____

Medical History

Do you have any allergies to medications? □ No □ Yes If yes, what medications: _____

_____

List any medications you currently take (including over the counter, vitamins, and eye medications):

_____

_____

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

_____

Are you pregnant or nursing? □ No □ Yes

Do you wear glasses? □ No □ Yes If yes, how old is your present pair of lenses? _____

Do you wear contacts? □ No □ Yes If yes, how old is your present pair of lenses? _____

If no, are you interested in contacts? □ No □ Yes

Type of contacts: □ Rigid □ Soft □ Extended Wear □ Other

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

Disease/Conditions	No	Yes
Blindness	□	□
Glaucoma	□	□
Macular Degeneration	□	□
Retinal Detachment/Disease	□	□

Important New Patients!

Who may we thank for referring you?

Name of friend or relative: _____

If not referred, how did you choose our office?

□Another Dr. □ Saw Sign/Building

□ Insurance List □ Yellow pages

□ Website □Other: _____

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Social History

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

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

Do you use illegal drugs? □ No □ Yes If yes, type / amount / how long: _____

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

	No	Yes
Allergic/Immunologic		
Drug allergy	□	□
Environmental	□	□
Rheumatoid Arthritis	□	□
Lupus	□	□
Other: _____		
Eyes		
Glaucoma	□	□
Macular degeneration	□	□
Surgery	□	□
Blurred vision	□	□
Double vision	□	□
Dry/itchy	□	□
Other: _____		
Musculoskeletal		
Fibromyalgia	□	□
Muscular dystrophy	□	□
Osteoarthritis	□	□
Other: _____		
Cardiovascular		
Heart disease	□	□
High Blood Pressure	□	□
Stroke	□	□
Other: _____		
Gastrointestinal		
Crohn's	□	□
Colitis	□	□
Other: _____		
Neurological		
Multiple sclerosis	□	□
Parkinson's	□	□
Headaches	□	□
Other: _____		

	No	Yes
Constitutional		
Developmental disability	□	□
Fever	□	□
Other: _____		
Genitourinary		
STD, viral herpetic	□	□
Chlamydia	□	□
Other: _____		
Psychiatric		
Depression	□	□
Panic disorder	□	□
Schizophrenia	□	□
Other: _____		
Ear, Nose, Mouth, and Throat		
Upper Resp. Tract Infection	□	□
Hematologic/Lymphatic		
Anemia	□	□
Leukemia	□	□
Other: _____		
Respiratory		
Asthma	□	□
Bronchitis	□	□
Emphysema	□	□
Other: _____		
Endocrine		
Diabetes	□	□
Thyroid dysfunction	□	□
Other:	□	□
Integumentary (skin)		
Eczema	□	□
Rosacea	□	□
Psoriasis	□	□
Other: _____		

If you answered YES to any of the above or have a condition not listed, please explain and list medication:

_____

_____

_____