

The Eyecare Center of Madison
EYE HEALTH AND MEDICAL HISTORY

Patient's Name _____ **Date completed** _____

The following information about your medical and eye health history will be an important part of your records at The Eyecare Center. If you need help with any part of the form, please ask a staff member or doctor. **Please be assured that all of your medical records will be held in the strictest confidence.**

Personal Medical Status and History Please check Yes or No for *each* listed category or condition as it applies to you **PERSONALLY** (family medical history is on reverse). Add details/comments as needed.

System	Y	N	Describe or Comment	System	Y	N	Describe or Comment
Eye Disease(s)				Genitourinary			
Cataracts				(specify)			
Glaucoma				Musculoskeletal			
Macular Degen.				Osteo Arthritis			
“Lazy Eye”				Fibromyalgia			
Injury				Other (specify)			
Dry Eyes				Endocrine/Gland			
Eye Surgery				Diabetes			
Other (specify)				Thyroid			
Cancer				Other (specify)			
(specify)				Allergic/Immune			
Ear/Nose/Throat				Rheum. Arthritis			
Sinus				Allergies (specify)			
Other (specify)				Other (specify)			
Neurological				Mental/Psych.			
Migraine				Depression			
Other (specify)				Bipolar			
Gastrointestinal				ADHD			
Acid Reflux				Alzheimer's			
Irritable Bowel				Other (specify)			
Other (specify)				Skin (specify)			
Cardiovascular				Respiratory			
Blood Pressure				Asthma			
Stroke				COPD			
Heart disease				Other (specify)			
Cholesterol				Blood/Lymph			
Irreg. Heartbeat				Anemia			
Other (specify)				Other (specify)			

Drug allergies? No Yes (please list): _____

Please list all current medications and supplements (or check: written list attached) _____

Prior Surgeries & approx. dates _____

Primary Physician/Doctor(s) _____ Pharmacy Preferred _____

Specialists/Other Health Practitioners _____

(Over please)

MEDICAL AND EYE HEALTH HISTORY (Cont'd)

Social History (Age 14 & over only) Do you drive? No Yes Use Tobacco Products? No Yes Alcohol? No Yes

Use Illegal drugs or other substances? No Yes Have you been affected by hepatitis, HIV or any other STD's? No Yes

Comments (optional):

If Child/Teen (under age 18 only): List any developmental disabilities, pre- or post-natal complications, significant illnesses, etc.

Family Eye & Medical History Please mark Y, N or ? for each condition for your blood relatives. If not available (for example, if you were adopted, etc.) please indicate accordingly.

Disease/Condition	Y	N	?	Relationship to You/Comments	Office Use/Notes
Glaucoma					
Cataracts					
Blindness					
Crossed/"Lazy" eye					
Macular Degeneration					
Retinal Detachment					
Other Eye Disease(s)					
Diabetes					
Cardiovascular					
Cancer					

OFFICE USE ONLY (For staff/doctor use during future reviews / return visits)

Date	New problem(s) / changes in health history or status	Staff	Dr.
	<input type="checkbox"/> None (stable)		
	<input type="checkbox"/> None (stable)		
	<input type="checkbox"/> None (stable)		
	<input type="checkbox"/> None (stable)		
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