McDowell Eye Care
Patient History Form

Today's Date: _____/_____/_____

Full Name: _____ Birth Date: _____/_____/_____

Street:_____ Social Security #: _____

City:_____State:_____Zip:_____ Home Phone: _____

Email: _____ Cell Phone: _____

May we contact you regarding your next appointment via email? ☐ Yes ☐ No Via text? ☐ Yes ☐ No

Occupation: _____ Work Phone: _____

Employer: _____

Vision Insurance: _____ Policy number: _____

Policy holder's name: _____ Policy holder's birthdate: _____/_____/_____

Responsible party, if different: _____ Relationship to patient: _____

Phone: _____ Billing Address: _____

Medical Doctor: _____ Last Medical Exam:_____/_____/_____

Medical Insurance: _____ Policy number: _____

Who may we thank for referring you to our office: _____

EYE HISTORY Do you wear eyeglasses? ☐ Yes ☐ No Do you wear contact lenses? ☐ Yes ☐ No

Previous Eye Doctor: _____ Last Eye Exam: _____ /_____ /_____

Have you had any eye surgeries? ☐ Yes ☐ No If yes, Date_____ Type _____

Are you having any vision difficulties? ☐ Yes ☐ No If yes, please explain _____

_____

Are you currently experiencing any of the following problems with your eyes?

☐ Blurred Vision	☐ Flashes/Floaters in Vision	☐ Redness
☐ Loss of Vision	☐ Halos/Glares/Light Sensitivity	☐ Excess Tearing / Watering
☐ Loss of Side Vision	☐ Dryness	☐ Eye Pain
☐ Distorted Vision	☐ Sandy or Gritty Feeling	☐ Mucous Discharge
☐ Double Vision	☐ Burning	☐ Inflammation of the Eyelid
☐ Tired Eyes	☐ Itching	☐ Styes

Have you been diagnosed with any of the following eye problems?

☐ Cataracts	☐ Glaucoma	☐ Retinal Detatchment/Disease
☐ Crossed Eyes	☐ Lazy Eye/Amblyopia	☐ Dry Eye
☐ Eye Injury	☐ Macular Degeneration	☐ Other_____

• PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED • Thank you!

MEDICAL HISTORY

List any medications you are currently taking (include oral contraceptives, aspirin, over the counter medications):

_____

_____

Are you allergic to any medications? ☐ No ☐ Yes If yes, which: _____

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

Please check the box beside any problem you currently have, or have had:

Allergic / Immunologic ☐ All normal
☐ Seasonal / Hay Fever ☐ Other _____

Cardiovascular / Cardiac ☐ All normal
☐ Arteriosclerosis ☐ Other _____
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol

Constitutional ☐ All normal
☐ Weight Loss / Gain ☐ Other _____

Ears, Nose, Mouth, Throat ☐ All normal
☐ Sinus Congestion ☐ Other _____
☐ Dry Throat / Mouth

Endocrine ☐ All normal
☐ Diabetes ☐ Other _____
☐ Thyroid Disease
☐ Chronic Fatigue

Gastrointestinal ☐ All normal
☐ Reflux ☐ Other _____
☐ IBS / Crohn's Disease
☐ Ulcers

Genitourinary ☐ All normal
☐ Kidney Disease ☐ Other _____
☐ Ovarian / Uterine Cancer
☐ Prostate Cancer

Hematologic / Lymphatic ☐ All normal
☐ Anemia ☐ Other _____
☐ Bleeding Problems
☐ Breast Cancer

Integumentary (Skin) ☐ All normal
☐ Cancer ☐ Other _____
☐ Rashes
☐ Easy Bruising

Musculoskeletal ☐ All normal
☐ Rheumatoid Arthritis ☐ Other _____
☐ Muscle Pain
☐ Joint Pain

Neurological ☐ All normal
☐ Migraines ☐ Other _____
☐ Dizziness
☐ Seizures
☐ Stroke

Psychiatric ☐ All normal
☐ Anxiety ☐ Other _____
☐ Depression
☐ Memory Loss
☐ Hallucinations

Respiratory ☐ All normal
☐ Asthma ☐ Other_____
☐ Emphysema

For women, are you pregnant or nursing? ☐ Yes ☐ No Due date: _____

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

☐ Glaucoma ☐ Cataract ☐ Macular Degeneration ☐ Retinal Detachment ☐ Blindness ☐ Crossed Eyes

If you checked any above boxes, please list relation to you: _____

Signature_____ Please sign in person at McDowell Eye Care **Date**_____/_____/_____