EXACT EYE CARE - Medical History

Name _____ DOB _____ Gender: M / F
(Please Print)

Are you covered by Medicaid / Medicare (circle) Age _____ Today's Date _____

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

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

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

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

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

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	
☐	☐	Glaucoma	☐	☐	Diabetic Retinopathy	☐	☐	Diabetes
☐	☐	Macular Degeneration	☐	☐	Retinal Detachment	☐	☐	High Blood Pressure
☐	☐	Cataracts	☐	☐	Blindness	☐	☐	Other

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

SOCIAL HISTORY

Occupation: _____

Hobbies: _____

Yes	No	
☐	☐	Do you smoke?
☐	☐	Do you drink alcohol?
☐	☐	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 conditions of the eye such as glaucoma and macular degeneration as well as diseases of the body such as diabetes and hypertension. Eyedrops 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.

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

Patient's Signature _____ **Date** _____

Reviewed On: date/initials _____ _____ _____