Dr. Black's eye associates

(888) EYE-CARE
www.Have2020.com

MEDICAL HISTORY

Patient Name:_____ Date:_____

Email Address:_____ Emergency Contact:_____

Pharmacy:_____ Primary Care Physician_____

Date of Birth:_____ Date of Last Eye Exam:_____

Ethnicity: Hisp____ Non Hisp____ Preferred Language: English / Other_____ Race:_____

Do you wear contacts? ❑ Yes ❑ No Do you wear glasses? ❑ Yes ❑ No

Eye Symptoms

	YES	NO		YES	NO		YES	NO		YES	NO
Blurred Vision			Burning			Discharge			Flashes of Light		
Loss of Vision			Tearing			Pain			Floaters or Spots		
Redness			Itching			Dry Eyes			Glare or Halos		

Other _____

Review of Symptoms - Please answer YES or NO for each question

	YES	NO		YES	NO		YES	NO		YES	NO
Fatigue			Shortness of Breath			Heat Intolerance			Joint Pain		
Fever			Chest Pain			Increased Thirst			Joint Swelling		
Hearing Loss			Irregular Heartbeat			Increased Urination			Muscle Weakness		
Congestion			Abdominal Pain			Dizziness			Bleeding/Bruising		
Sore Throat			Nausea			Depression			Food Allergies		
Cough			Cold Intolerance			Rash			Seasonal Allergies		

Please List medications you are currently taking (including eye medications)

Medication Name	Dosage	Medication Name	Dosage

Are you allergic to any medications? YES____ NO_____ If YES:_____

Ocular History - Please answer YES or NO for each question

	YES	NO		YES	NO		YES	NO		YES	NO
Cataracts			Macular Degeneration			Injury			Crossed/ Lazy Eye		
Glaucoma			Retinal Detachment			Surgery			Laser Treatments		

Eye Surgery or Other Procedure:_____

Medical History - Please answer YES or NO for each question

	YES	NO		YES	NO		YES	NO		YES	NO
ENT/Sinus			Diabetic ____yrs.			Kidney Disease			Cancer		
Migranes			High Blood Pressure			Lung Problems			Thyroid		
Arthritis			Skin Disorders			Heart Disease/Stroke			Immune Disorders		

Surgery/Other Procedures:_____

Females: Are you currently pregnant or nursing? ❑ Yes ❑ No

Family History - Please answer what applies directly to First Generation Relatives (Mother, Father, Sister, Brother)

Cataracts: YES____ Relation_____Glaucoma: YES____ Relation_____ Diabetes: YES____ Relation_____

Macular Degeneration: YES____ Relation_____ Retinal Detatchment: YES____ Relation_____

Social History - Please answer YES or NO and fill out any other information

Do you smoke? YES____ NO____ Packs a Day/Years:_____ Former Smoker? YES____ NO____

Are you at risk for falls? YES____ NO ____ How many falls in the last year? ____ Did the fall result in injury? YES____NO____