

Name _____ Birth Date _____

Many insurance companies now require a complete medical history as a part of your eye examination.
Please provide as much of the following information as possible.

Social Sec # _____ Date this form was originally completed: _____

Physician's Name _____ Last Physical Exam Date _____
Address _____

Family History (Please note any parents, grandparents, or siblings living or deceased who had the following conditions):

	Relationship to you		Relationship to you
Blindness	_____	Diabetes	_____
Cataract	_____	Cancer	_____
Crossed Eyes	_____	Heart Disease	_____
Glaucoma	_____	High Blood Pressure	_____
Macular Degeneration	_____	Kidney Disease	_____
Retinal Detachment	_____	Thyroid Disease	_____
Arthritis	_____	Other	_____

Social History (I would prefer to discuss my social history with Dr Hogue.)

Marital Status	Single	Married	Separated	Divorced	Widowed
Do you drive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Use of alcohol	Never	Rarely	Moderately	Daily	
Use of tobacco	Never	Previously	Currently	Packs per day	_____
Illicit drug use	Never	Type	_____	Frequency	_____
Exposure/Infected	Hepatitis	Gonorrhea	HIV	Syphilis	
Are you pregnant	_____	or nursing	_____		

Eye conditions treated by previous doctors:

<input type="checkbox"/> Pink Eye	<input type="checkbox"/> Dry Eye	<input type="checkbox"/> Watery /Itching Eyes	<input type="checkbox"/> Floaters	<input type="checkbox"/> Flashes	<input type="checkbox"/> Eye Injury _____
<input type="checkbox"/> Cataract	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Double vision	<input type="checkbox"/> Lazy Eye	<input type="checkbox"/> Other _____
Surgery for:	<input type="checkbox"/> Cataract	<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Radial K	<input type="checkbox"/> Lasik	<input type="checkbox"/> Eye Muscle Correction

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

	No	Yes	If yes, please explain (include any Medications you are taking)
Neurological			
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures/Tremors	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular			
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain/palpitation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling of feet/ankles/hands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constitutional			
Poor general health lately	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine			
Thyroid or glandular problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive thirst or urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please fill out back of form

