MEDICAL HISTORY UPDATE

Name: _____ **Today's Date:** _____

Please list all of your current medications (including oral contraceptives, aspirin, over-the-counter medications, vitamins and supplements) _____

_____

_____

_____

Are you allergic to any of the following? (If yes, please explain the type of reaction)

Medication		Type of Reaction
Penicillin	yes/no	_____
Sulfa	yes/no	_____
Codeine	yes/no	_____
Latex	yes/no	_____
Other	_____	

Has anyone in your IMMEDIATE FAMILY been diagnosed with:
(If so please list who, i.e. mother, father, brother, sister, son, daughter)

Cancer	yes/no	_____
Type I Diabetes	yes/no	_____
Type II Diabetes	yes/no	_____
Hypertension	yes/no	_____
Hyperthyroidism	yes/no	_____
Hypothyroidism	yes/no	_____
Cataract	yes/no	_____
Macular Degeneration	yes/no	_____
Glaucoma	yes/no	_____
Heart Disease	yes/no	_____

Primary Care Physician

Primary Care Physician _____ Phone number PCP_____

FOR CONTACT LENS WEARERS ONLY

How old are your current contact lenses that you are wearing? _____
Do your eyes get dry with the contact lenses you currently wear? _____
How often do you change out your current contact lenses? _____
How comfortable are your current contacts? _____
How long do you spend looking at a screen in an average day? (i.e. computer, phone, tablet,tv)
_____

All patients please read and sign below

I authorize Drs Eyecare to release any medical information to my insurance company (or companies) and to accept assignment of benefits. I understand that I may have co-payments and overages (costs not paid for by the eye care and/or medical plan), and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature _____ Date:_____

Notice of Privacy Practices Acknowledgment

I acknowledge that I received a copy of Drs Eyecare's Notice of Privacy Practices.

Patient Name: _____ Date: _____

Signature:_____

REVIEW OF SYSTEMS: Do you have any health problems related to the following? Please circle. If yes, please explain.

SYSTEM	YES/NO	NOT SURE	EXPLAIN/MEDICATIONS
I. Skin	yes/no	?	
II. Neurological			
1. Headaches/Migraines	yes/no	?	
2. Seizures	yes/no	?	
III. Eyes			
1. Loss of Vision	yes/no	?	
2. Double Vision	yes/no	?	
3. "Pink"/ Red eye	yes/no	?	
4. Light Sensitive	yes/no	?	
5. Eye Pain	yes/no	?	
6. Eye Infections	yes/no	?	
7. Watery Eyes	yes/no	?	
8. Dry Eyes	yes/no	?	
IV. Ears, Nose, Mouth, Throat			
1. Allergies	yes/no	?	
2. Hay Fever	yes/no	?	
3. Sinus Congestion	yes/no	?	
4. Runny Nose	yes/no	?	
5. Dry Throat/ Mouth	yes/no	?	
6. Ear Infections	yes/no	?	
V. Respiratory			
1. Asthma	yes/no	?	
2. Chronic Bronchitis	yes/no	?	
3. Emphysema	yes/no	?	
VI. Vascular Disease			
1. Diabetes	yes/no	?	
2. High Blood Pressure	yes/no	?	
3. Vascular Disease	yes/no	?	
VII. Gastrointestinal			
1. Diarrhea	yes/no	?	
2. Constipation	yes/no	?	
VIII. Genitourinary			
1. Genitals	yes/no	?	
2. Kidney/Bladder	yes/no	?	
IX. Bones/Joints/Muscles			
1. Rheumatoid Arthritis	yes/no	?	
2. Muscle/Joint Pain	yes/no	?	
X. Lymphatic/Hematological			
1. Anemia	yes/no	?	
2. Bleeding Problems	yes/no	?	
XI. Endocrine			
1. Thyroid/Other	yes/no	?	
XII. Psychiatric			
1. Anxiety	yes/no	?	
2. Depression	yes/no	?	
XIII. Constitutional			
1. Fever	yes/no	?	