Medical History and Information

Patient Demographics: (Circle where applicable)

Last Name, First Name________________________________
Address____
City______________State_____Zip code________________
Sex: Male or Female
Date of Birth(MM/DD/YYYY)__________________________
Email :____
Cell Phone:____
Home Phone:____
Last Eye Doctor_____________________________________
Primary Care Physician_______________________________

Social Security #_________________________________
Marital Status: Single Married Divorced Widowed
Occupation:______________________________________
Employer:_______________________________________
Vision Insurance:_________________________________
Policy/ID #_______________________________________
Medical Insurance:________________________________
Policy/ID#:______________________________________
Last Eye Exam:___________________________________
Last Exam _______________________________________

How did you hear about Riverview Eye Care?____

Reason for today's visit:____

Are you interested in a contact lens exam? Yes No
Please Circle One (if applicable): Current Contact Lens Wearer or Interested in Wearing Contact Lenses
Current Contact Lens Wearers: Please answer the questions below (skip if not applicable):
Approximately how many hours a day do you wear your Contacts?___________________________________
Do you sleep overnight with your contact lenses?__________If yes, how many nights/week________________
How often do you replace your Contact Lenses?____
What brand of Contact Lens Solution do you use?____

Do you currently wear glasses? Yes No
If yes, do you have more than one pair? Yes No
How old are your current glasses?____
Primary use: All the time Reading Computer Night Driving Other_____________________

Have you had any Eye Surgery? Yes or No (If yes, please specify):________________________________

Ocular History:

Have you ever been diagnosed with any of the following eye conditions? (Please circle all that apply)

Cataract	Diabetic Retinopathy	Iritis or Uveitis
Age Related Macular Degeneration	Dry Eye	Retina Tears/Degeneration
Glaucoma	Eye Infection or Allergy	Eye Trauma
Diabetes	Floaters and/or Flashes of Light	Crossed or Lazy Eye

Eye & Vision Concerns: Are you currently experiencing any of the following? (Circle all that apply)

Redness	Blurred Vision	Poor Night Vision
Burning	Eye Strain	Bothersome Night Glare
Itching	Eye Pain	Double Vision
Tearing	Severe Sensitivity to Lights	Total Loss of Vision
Discharge	Headache	Other_______________________

Review Of Systems: (Please circle all that apply)

Constitutional
Developmental Disabilities
Cancer
Fatigue

Ears/Nose/Throat
Hearing Loss
Sinusitis
Dry Mouth
Laryngitis

Respiratory
Cigarette Smoker
Asthma
Bronchitis
Emphysema
Chronic Obstruction
Sleep Apnea

Endocrine
Type 2 Diabetes
Type 1 Diabetes
Thyroid Dysfunction
Hormonal Dysfunction

Neurological
Multiple Sclerosis
Epilepsy
Cerebral palsy
Tumor
Stroke/Brain Related
Migraine
Autism

Gastrointestinal
Crohn's
Colitis
Ulcer
Acid Reflux
Celiac Disease

Integumentary
Eczema
Rosacea
Psoriasis
Herpes Simplex
Herpes Zoster

Psychiatric
Depression
Attention Deficit
Anxiety Disorder
Bipolar Disorder

Cardiovascular
Hypertension
Stroke/CVA
Heart Disease
Vascular Disease
Congestive Heart Failure
Hypercholesteremeia

Genitourinary
Kidney Disease
Prostate Disease/Cancer
Herpetic/Chlamydia
Prostate

Hematologic/Lymphatic
Anemia
Ulcer
Immune
Rheumatoid Arthritis
Lupus
Sjogren's Syndrome

Medical History:

Are you currently Pregnant or Nursing? Yes No

Please List *ALL* medications you are taking, including eye drops:____

____

____

Please list any allergies you may have (along with reaction):____

____

Social History: (Please note that this information is strictly confidential)

Alcohol use: Never Social 1-2 Daily 2 or more daily Alcohol Dependency

Tobacco Use: Never Smoked Current Smoker (Packs/day)______________ Former Smoker (quit)________

Social Hobbies____

Family Medical/Ocular History:

Please indicate which family member had the following. Please indicate Maternal or Paternal and relation.

Cataracts___________________________________
Eye Turn/ Lazy Eye___________________________
Glaucoma___________________________________
Color Blindness______________________________
Cornea Problems_____________________________
Macular Degeneration_________________________
Retinal Problems_____________________________

Diabetes______________________________________
High or Low Blood Pressure_____________________
Heart Disease_________________________________
Cholesterol___________________________________
Thyroid ______________________________________
Cancer_______________________________________
Other____

By signing this form, you acknowledge that the above information is complete and accurate to the best of your knowledge.

Signature:____**Date:**______________________________