Reinert Family Eye Care

EyeCare Plus – Medical History Form

Today's Date:_____

Name:_____ Patient#:___N/A___ Date Of Birth: ___/___/___

Marital Status: _____ Male / Female (Circle) Race/Ethnicity: _____

Purpose for today's visit:_____

Interested in contact lenses or LASIK surgery? _____

Are you currently experiencing the following?

Headaches	Blurry Vision	Trouble seeing at night	Double Vision
Burning	Eye Injury	Itching	Sunlight Sensitivity
Pain	Tearing	Dry Eye	Foreign Body

Other:_____

Have you ever been diagnosed or treated for the following? When was your last eye exam (approx)? _____

Corneal Abrasion	Cataracts	Lazy Eye	Retinal Detachment	Blindness	Angle Closure
Floaters/Flashes	Eye Trauma	Glaucoma	Iritis/Uveitis	Macular Degeneration	

Check ***ALL*** that apply: (for Family: only list PARENTS or SIBLINGS - please specify parent)

	Yourself	Family		Yourself	Family
AIDS/HIV	_____	_____	HEPATITIS (Type A, B, or C)	_____	_____
ARTHRITIS	_____	_____	MIGRAINES	_____	_____
ASTHMA	_____	_____	PACEMAKER	_____	_____
AUTOIMUNE DISORDER	_____	_____	SEIZURES/EPILEPSY	_____	_____
BLEEDING DISORDER	_____	_____	SHINGLES	_____	_____
CANCER: Type:_____	_____	_____	STROKE	_____	_____
DIABETES (TYPE 1 OR 2)	_____	_____	THYROID DISORDER	_____	_____
HEART DISEASE	_____	_____	TUBERCULOSIS	_____	_____
HYPERTENSION	_____	_____	HIGH CHOLESTEROL	_____	_____

OTHER:_____

FAMILY HISTORY:

Macular Degeneration ____ Blindness ____ Glaucoma ____ Retinal Detachment ____

Alcohol Use? Y / N If yes, circle one: Rarely / Occasionally / Daily

Tobacco Use? Y / N If yes: circle one: Former smoker / Light smoker / Heavy smoker (more than 10 per day) / Smokeless tobacco only

Primary care physician:_____ Pregnant or Nursing? Y / N

Please list **ALL** current medications: *(if you prefer, we can make a copy of your list.)*

_____

_____

_____

Medication allergies:_____

_____

_____

Occupation: _____