Patient Name: _____ **Date:** _____

MEDICAL HISTORY

Height: _____ ft. _____ in. **Weight**: _____ lbs. **Blood Pressure**: _____ / _____

Family Physician: _____ **Address**: _____

Date Last Seen: _____ **Reason for Visit:** _____ **Phone**: _____

Preferred Pharmacy: _____ **City:** _____

Have you been to our office before: No ( ) Yes ( ) **Date of Last Eye Exam**: _____

Current Hobbies: _____ **Job Description:** _____

EYE INFORMATION (WITH GLASSES OR CONTACTS ON)

Difficulty with Distant vision	No ( ) Yes ( )	Wear eyeglasses	No ( ) Yes ( )
Difficulty with Near vision	No ( ) Yes ( )	Wear Contacts	No ( ) Yes ( )
Significant eye pain	No ( ) Yes ( )	Wear Sunglasses	No ( ) Yes ( )
Frequent headaches	No ( ) Yes ( )	Interest in Contacts	No ( ) Yes ( )

What is the reason for today's visit? _____

DO **YOU** HAVE ANY OF THESES PROBLEMS WITH YOUR EYES…

	N	Y		N	Y
Blindness	( )	( )	Burning or Itching	( )	( )
Loss of Vision	( )	( )	Sandy or gritty feeling	( )	( )
Distorted Vision	( )	( )	Glare/ Light Sensitivity	( )	( )
Crossed or Lazy Eyes	( )	( )	Chronic Eye Infections	( )	( )
Blurred Vision	( )	( )	Tired Eyes	( )	( )
Double Vision	( )	( )	Halos	( )	( )
Cataracts	( )	( )	Eye Surgery	( )	( )
Flashes	( )	( )	Eye Injury	( )	( )
Floaters	( )	( )	Retinal Detachment	( )	( )
Dry Eyes	( )	( )	Glaucoma	( )	( )
Watery Eyes	( )	( )	Color Vision	( )	( )
Red Eyes	( )	( )	Mucous Discharge	( )	( )

FAMILY EYE HISTORY

Do you have a **family** history of (**if yes, indicate whom and circle it's (M) maternal or (P) paternal**):

Blindness	No ( )	Yes ( )	_____	M	P	Glaucoma	No ( )	Yes ( )	_____	M	P
Macular Degeneration	No ( )	Yes ( )	_____	M	P	Cataract	No ( )	Yes ( )	_____	M	P
Diabetes	No ( )	Yes ( )	_____	M	P	Retinal Detachment	No ( )	Yes ( )	_____	M	P
Eye Tumors	No ( )	Yes ( )	_____	M	P	Amblyopia (Lazy Eye)	No ( )	Yes ( )	_____	M	P

PAST, FAMILY AND/OR SOCIAL HISTORY

Is there anything in your past history, family history or social history which would help us care for you?

Describe: _____

- Past History (illness, operations, injuries, medications, treatment) No ( ) Yes ( ) _____
- Family History (diseases, hereditary, risk factors, etc.) No ( ) Yes ( ) _____
- Social History (past and current activities)
  - **Do you use any of the following products?**

Alcohol No ( ) Yes ( ) **Recreational Drugs** No ( ) Yes ( )

Smoking Status: ( ) Never Smoker ( ) Former Smoker ( ) Smoker ( ) Current Every Day Smoker ( ) Current Some Day Smoker

Are you pregnant? No ( ) Yes ( ) **Preferred Language:** _____

Have you been exposed to any sexually transmitted disease(s)? No ( ) Yes ( ) If Yes, Explain: _____

Ethnicity (please select one): ( ) Hispanic or Latino ( ) Non-Hispanic or Latino

Race: ( ) American Indian or Alaska Native ( ) Asian ( ) Black or African American

( ) White ( ) Native Hawaiian or Other Pacific Islander

Are you taking any medications? No ( ) Yes ( ) **If yes, please list below:**

Name: _____ Dosage: _____ Name: _____ Dosage: _____

Name: _____ Dosage: _____ Name: _____ Dosage: _____

Name: _____ Dosage: _____ Name: _____ Dosage: _____

Name: _____ Dosage: _____ Name: _____ Dosage: _____

Name: _____ Dosage: _____ Name: _____ Dosage: _____

Are you allergic to any medications? No ( ) Yes ( ) **If yes, please list below:**

Name: _____ Reaction: _____ Name: _____ Reaction: _____

Name: _____ Reaction: _____ Name: _____ Reaction: _____

Do you have any other health problems? No ( ) Yes ( )

If yes, please list: _____

REVIEW OF SYSTEMS – Do you have a problem with…

	N	Y
GENERAL SYMPTOMS		
Fever	( )	( )
Weight Loss	( )	( )
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	( )	( )
Sinus Problems	( )	( )
Dry Throat/ Mouth	( )	( )
Chronic Ear Infections	( )	( )
CARDIOVASCULAR		
Heart/ Chest Pain	( )	( )
High Blood Pressure	( )	( )
Vascular Disease/ Strokes	( )	( )
RESPIRATORY		
Asthma	( )	( )
Shortness of Breath	( )	( )
Emphysema	( )	( )
Lung Cancer	( )	( )
GEITOURINARY		
Genitals	( )	( )
Kidneys	( )	( )
Bladder	( )	( )
MUSCULOSKELETAL		
Arthritis	( )	( )
Rheumatoid Arthritis	( )	( )
Muscle Pain	( )	( )
Joint Pain	( )	( )

	N	Y
INTEGUMENTARY		
Skin Diseases	( )	( )
Rashes	( )	( )
Breast	( )	( )
NEUROLOGICAL		
Headaches	( )	( )
Migraines	( )	( )
Seizures/ Brain Injury	( )	( )
PSYCHIATRIC		
Nervous Disorders	( )	( )
Depression	( )	( )
Compulsive Behavior	( )	( )
ENDOCRINE		
Diabetes	( )	( )
Thyroid Problems	( )	( )
Other Glands	( )	( )
HERMATOLOGIC/ LYMPHATIC		
Anemia	( )	( )
Bleeding Problems	( )	( )
Swelling	( )	( )
ALLERGIC/ IMMUNOLOGIC		
Hay Fever	( )	( )
Medicine Allergies	( )	( )
H1N1 Virus	( )	( )
GASTROINTESTINAL		
Ulcers	( )	( )
Other GI problems	( )	( )

I allow my examination findings to be shared with other professionals responsible for my care. I acknowledge that I have received and read a copy of iCare Vision Centers' Notice of Privacy Practices.

Signature_____ Date _____

If UNDER 18, Guardian Signature _____ Date _____

Signature 2nd YEAR _____ Date _____

Signature 3rd YEAR _____ Date _____

FOR OFFICE STAFF ONLY ----------

Doctor's Signature: _____ Date _____ (black)

Hx ( ) Changes ( ) No Changes / Dr. Signature: _____ Date _____ (red)

Hx ( ) Changes ( ) No Changes / Dr. Signature: _____ Date _____ (green)