FAMILY EYECARE OF GLENDALE

Medical Information Form (Please Print)

Name_____ Date of Birth:_____

(Last) (First) (M.I.)

Family Physician: _____ Date of Last Medical Exam: _____

Previous Eye Dr.: _____ Date of Last Eye Exam: _____

Do you wear, or have you ever worn: _____ Glasses _____ Contact Lenses

List any medications you take (including BCP's, vitamins, nutritional supplements, etc.):_____

_____

_____

Are you allergic to any medications? No____ Yes____ List: _____

List any surgeries you have had (e.g., eye surgery, cataract, tonsillectomy, appendectomy etc.) _____

_____

Social History *This information is kept strictly confidential...*

I would prefer to discuss my Social History information directly with my doctor. (Check box)

Are you pregnant? Yes No

Do you use tobacco products? Yes No If yes, type/amount/how long _____

Do you drink alcohol? Yes No If yes, type/amount/how long _____

Do you use illegal drugs? Yes No If yes, type/amount/how long _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Please indicate if **family members** have, or have had, any problems in the following areas:

Disease/Condition	**Indicate Family Member**	**Disease/Condition**	**Indicate Family Member**
Blindness	_____	Arthritis	_____
Cataract	_____	Cancer	_____
Crossed Eyes	_____	Diabetes	_____
Glaucoma	_____	Heart Disease	_____
Macular Degeneration	_____	High Blood Pressure	_____
Retinal Detachment/Disease	_____	Kidney Disease	_____
Other _____	_____	Lupus	_____
		Thyroid Disease	_____

CONTINUED ON OTHER SIDE

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

	Yes	No
CONSTITUTIONAL		
Weight Loss/Gain		
Fever		
NEUROLOGICAL		
Headaches		
Migraines		
Seizures		
EYES		
Blindness		
Cataract		
Crossed Eyes		
Glaucoma		
Macular Degeneration		
Retinal Detachment/Disease		
Loss of Vision		
Blurred Vision		
Distorted Vision/Halos		
Loss of Side Vision		
Double Vision		
Dryness		
Mucus Discharge		
Redness		
Sandy or Gritty Feeling		
Itching		
Burning		
Foreign Body Sensation		
Excess Tearing/Watering		
Glare/Light Sensitivity		
Eye Pain or Soreness		
Chronic Infection of Eye or Lid		
Frequent Styes		
Flashes/Floaters		
Eye Fatigue		
ENDOCRINE		
Thyroid		
Pituitary		
Other Glands		
Cholesterol		

	Yes	No
EARS/ NOSE/ MOUTH/ THROAT		
Allergies/Hay Fever		
Sinus Congestion		
Runny Nose		
Post-Nasal Drip		
Chronic Cough		
Dry Throat/Mouth		
RESPIRATORY		
Asthma		
Chronic Bronchitis		
Emphysema		
VASCULAR/ CARDIOVASCULAR		
Diabetes		
Heart Pain		
High Blood Pressure		
Vascular Disease		
GASTRO-INTESTINAL		
Diarrhea		
Constipation		
GENITO-URINARY		
Genitals/Kidney/Bladder		
BONES/ JOINTS/ MUSCLES		
Rheumatoid Arthritis		
Muscle Pain		
Joint Pain		
LYMPHATIC/ HEMATOLOGIC		
Anemia		
Bleeding Problems		
ALLERGIC/ IMMUNOLOGIC		
Lupus		
Cancer		
PSYCHIATRIC		

I hereby authorize Family EyeCare Associates to release any information required to my insurance carrier to process this claim. I also acknowledge that I am financially responsible for all non-covered charges. Office policy requires payment at the time our services are provided, unless prior arrangements have been made. There will be a 1.5% per month (18% per annum) service charge for patients requiring a monthly statement, and a $30.00 service fee for returned checks.

_____ _____

Signature of Account Responsible Party Date