Family Vision clinic

MEDICAL HISTORY

Today's date _____

Last Name _____ First Name _____ MI _____

Address _____ Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Would you like to get appointment reminders by text? Yes/No SSN _____-_____-_____

Occupation _____ Employer _____

Marital Status _____ D.O.B. _____

Race/Ethnicity ___ American Indian or Alaska Native ___ Asian ___ Black or African American ___ Hispanic

___ Multiracial ___ Native Hawaiian/other Pacific Islander ___ White

Emergency Contact Name _____ Emergency Contact Number _____

Year of last eye exam _____ Dilated? Yes/No

Email _____ @ _____

Responsible Party _____

Referred by _____

Family History

High blood pressure	Yes/No	Relation _____	Macular degeneration	Yes/No	Relation _____
Diabetes	Yes/No	Relation _____	Retinal detachment	Yes/No	Relation _____
Glaucoma	Yes/No	Relation _____	Cataracts	Yes/No	Relation _____
Thyroid Disease	Yes/No	Relation _____	Cancer	Yes/No	Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? _____

Have you had any eye operations? Yes/No Type _____ Date _____

Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma? Yes/No	Cataracts? Yes/No	Dry eyes? Yes/No	Crossed Eyes? Yes/No
Floaters/Flashes? Yes/No	Double Vision? Yes/No	Itching/Burning? Yes/No	Lazy Eye? Yes/No
Macular degeneration? Yes/No	Retinal detachment? Yes/No	Blurred Vision? Yes/No	Loss of Vision? Yes/No
Do you wear glasses? Yes/No	Contact lenses? Yes/No	Type _____	

Additional information _____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❒ Yes, I prefer to discuss my Social History information directly with Dr. Breaux.

Do you drive? ❒ No ❒ Yes If yes, do you have visual difficulty when driving? ❒ No ❒ Yes If yes, please describe:

_____

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

Are you a ❒ Former Smoker ❒ Current Occasional Smoker ❒ Current Everyday Smoker

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

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

– OVER –

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Medical History

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

_____

_____

Are you pregnant and/or nursing? ❒ No ❒ Yes

Do you have problems with any of the following:

Angina	Yes	No	Rosacea	Yes	No
High Cholesterol	Yes	No	Psoriasis	Yes	No
Congestive Heart Disease	Yes	No	Eczema	Yes	No
High Blood Pressure	Yes	No	Dermatitis/Dry Skin	Yes	No
Cardiovascular Disease	Yes	No	Lupus	Yes	No
Anemia/Appetite Problems	Yes	No	Vitiligo	Yes	No
Blackouts/Fainting	Yes	No	Arthritis	Yes	No
Dizziness/Weakness	Yes	No	Ankylosing Spondylitis	Yes	No
High Blood Sugar	Yes	No	Fibromyalgia	Yes	No
Hypoglycemia	Yes	No	Myasthenia Gravis	Yes	No
Pituitary/Thyroid Disorder	Yes	No	Marfan's Syndrome	Yes	No
Renal Disease	Yes	No	Osteoporosis (Early/Advanced)	Yes	No
Acid Reflux	Yes	No	Epilepsy/Seizures	Yes	No
Ulcer/Gastritis	Yes	No	Stroke/CVA	Yes	No
Colitis	Yes	No	Parkinson's Disease	Yes	No
Celiac Disease	Yes	No	Sturge-Weber Syndrome	Yes	No
Crohn's Disease	Yes	No	Von Hippel-Lindau Disease	Yes	No
Diverticulosis	Yes	No	Anxiety Disorder	Yes	No
Kidney Disease	Yes	No	Bi-Polar Disorder	Yes	No
Urinary Issues	Yes	No	Brain Damage (Trauma)	Yes	No
Headaches/Migraines	Yes	No	Memory Loss/Dementia	Yes	No
Dental Disorders/Gingivitis	Yes	No	Depression	Yes	No
Hearing Loss	Yes	No	Asthma	Yes	No
Sinusitis	Yes	No	COPD	Yes	No
Blood/Lymph	Yes	No	Emphysema	Yes	No
AIDS/HIV Positive	Yes	No	Lung Disease	Yes	No
Herpes Simplex/Shingles	Yes	No			

If yes to any, please explain _____

_____

_____

Diabetes Yes/No Type _____ Date of diagnosis _____

Allergies Yes/No Which? _____ Reactions? _____

Cancer Yes/No Please explain _____

Other health problems not listed: _____

Have you had any operations? Yes/No Kind? _____ When? _____

Name of family doctor _____

Date of last visit _____