# CLIFFSIDE EYE CENTER | PATIENT OCULAR & MEDICAL HISTORY FORM

| | |
|---|---|
| **Name:** | **Date:** |
| **Age:** **Phone:** | **Medical Doctor:** |
| **Diabetic? Yes No # of years:** | **Previous Eye Doctor:** |
| **Referred by:** | **Last Eye Exam:** |
| ☐**M.D.** ☐**Friend** ☐**Brochure** ☐**Internet** ☐**Mailing** | **E-mail:** |

**Reason for this visit:** ☐ Yearly exam to have glasses / contacts checked ☐ Vision has changed
☐ Diabetic Evaluation ☐ Cataract Evaluation ☐ Second Opinion ☐ LASIK Evaluation

**Any eye symptoms you have had:**

☐ Blurred Vison
☐ Dryness
☐ Cataracts
☐ Spots / floaters /flashes
☐ Reading Difficulty
☐ Glare / Halos

☐ Burning
☐ Stinging
☐ Itching
☐ Tearing
☐ Redness
☐ Tired Eyes
☐ Pressure

☐ Eye Fatigue
☐ Light Sensitivity
☐ Headaches
☐ Migraines
☐ Diabetes
☐ Poor Night Vision
☐ OTHER ______________________

**LIST ALL MEDICATIONS / PILLS /EYEDROPS:**

**DRUG ALLERGIES:** ☐ No ☐Yes Please list:

## Past, Medical, Family and Ocular History

| Medical History & System Review | | | Ocular History | | |
|---|---|---|---|---|---|
| ***Self*** | | ***Family*** | ***Self*** | | ***Family*** |
| ☐ | High blood pressure | ☐ | ☐ | Cataracts | ☐ |
| ☐ | Heart Condition: | ☐ | ☐ | Galucoma | ☐ |
| ☐ | Diabetes ______years | ☐ | ☐ | Macular Degeneration | ☐ |
| ☐ | Cancer: | ☐ | ☐ | Dry Eyes | ☐ |
| ☐ | Arthritis | ☐ | ☐ | Amblyopia / Lazy Eye | ☐ |
| ☐ | Respiratory Disease: | ☐ | ☐ | Retinal Disorders | ☐ |
| ☐ | Ear / Nose / Throat Problems: | ☐ | ☐ | Infections | ☐ |
| ☐ | Circulation Problems: | ☐ | ☐ | Eye Surgery | ☐ |
| ☐ | Neurological Problems: | ☐ | ☐ | Laser Treatment | |
| ☐ | Allergies: | ☐ | ☐ | LASIK | |
| ☐ | *Other:* | ☐ | ☐ | *Other:* | |

**Social History:** Please indicate your use of the following:
Alcohol ____# of drinks per week Smoking____# cigarettes per day ____yrs
Do you drive? ☐ Yes ☐No Hobbies & special interests: ______________________

What type of eyeglass lenses do you currently wear? ☐ Single Vision ☐Bifocal ☐Progressive
Are you satisfied with your current glasses? ☐ yes ☐no If no, explain______________________

What type of contact lenses do you wear? ☐ soft ☐ disposable ☐ gas perm

How many hours per day do you use a computer? ☐ 1-3 hrs ☐ 3-6 hrs ☐ 6+ hours

**Questions:**______________________

UPDATED: 1 2 3 4 5 6 7 8 9 10 11 12 / 201___ MD Signature______________________
1 2 3 4 5 6 7 8 9 10 11 12 / 201___