FAMILY FOCUS EYECARE

Health History Update

All information contained within this form is strictly confidential.
Please complete this document prior to your first appointment.

Name _____ Date _____

Primary Care Physician Name _____ Date of last medical exam_____

Primary Care Physician Office _____ Height _____ Weight

Do you take any diabetes medications? Yes No If yes, then last A1C and date _____

Are you a smoker? Yes No If yes, how many packs per day do you smoke? How many years have you smoked?

If no, did you smoke in the past? Yes No How many years ago did you quit?

Do you drink alcohol? Never Socially OR # of drinks per day _____

Please complete this portion of the form if there are ANY CHANGES to the following questions since your last visit

List any ocular history including trauma or injuries and any ocular surgeries:

_____

_____

_____

List of medications (Including eye drops and over-the-counter medications:

_____

_____

_____

List of Allergies and Reactions (Please include food and non-medication allergies)

_____

_____

_____

Family history of eye diseases and their relationship to you (maternal or paternal):

_____

_____

_____

Family history of any medical diseases and their relationship to you:

_____

_____

_____

General Medical History

Do you have any of the following?
(Check all that apply)

- Arthritis ☐
- Asthma ☐
- Cancer ☐
- Diabetes ☐
- Heart Disease ☐
- High Cholesterol ☐
- HIV ☐
- Hypertension (High blood pressure) ☐
- Stroke/ CVA ☐
- Migraines/headaches ☐
- Multiple Sclerosis ☐
- Thyroid Disease ☐
- Other: _____

_____

Primary Care Physician Name _____

Primary Care Physician Office _____

Height _____ Weight _____ Date of last medical exam _____

Please list any major surgeries:

_____

_____

_____

_____

Please List any medications you are currently taking and for what conditions:

_____

_____

_____

_____

Please list any drug allergies you have:

_____

_____

_____

_____

Social History

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

Do you drive? ☐Yes ☐No

Do you have visual difficulty when driving? ☐Yes ☐No

If yes, please describe _____

_____

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:

☐Hepatitis ☐HIV

Are you pregnant or nursing? ☐Yes ☐ No

Family History (Check all that apply)

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

	Yes	No	Relationship to You
Cancer	☐	☐	_____
Diabetes Mellitus	☐	☐	_____
Hyperthyroidism	☐	☐	_____
Hypothyroidism	☐	☐	_____
High Cholesterol	☐	☐	_____
High Blood Pressure	☐	☐	_____
Heart Disease	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Arthritis	☐	☐	_____
Blindness	☐	☐	_____
Eye turn/ Lazy Eye	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Cataracts	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____

Other _____