The Vision Clinic Medical History and Demographic Information Worksheet

Chart #_____

Please completely fill out **ALL sections of this information packet.**

Today's Date _____ Date of Birth _____ Age _____ Sex (circle one) M F

Name _____ Race _____

Preferred Language _____ Referred By _____ Social Security # _____

Address _____ City _____ State _____ Zip Code _____

Email _____ Communication Preference (circle one) Phone Text Email

Phone #1 _____ Phone #2 _____ Phone #3 _____

Medical Insurance _____ Member ID _____ Vision Insurance _____ Member ID _____

Current Medical Doctor _____ Most Recent Medical Exam _____

Previous Eye Doctor _____ Most Recent Eye Exam _____

Do you wear glasses? (circle one) Y N Do you wear contacts? (circle one) Y N

Reason for visit _____

Please continue explanations on the back of this page, if necessary.

Patient Ocular/Medical History	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Loss of Vision/Blindness		
Eye Turn/Strabismus		
Lazy Eye/Amblyopia		
Eye Infection		
Dry Eye		
High Blood Pressure/Hypertension		
Diabetes		
Other Disease(s)/Prematurity		

Previous Surgeries/Hospitalizations (please explain)

_____

_____

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Family Ocular/Medical History	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Loss of Vision/Blindness		
Eye Turn/Strabismus		
Lazy Eye/Amblyopia		
Eye Infection		
Dry Eye		
High Blood Pressure/Hypertension		
Diabetes		
Other Disease(s)/Prematurity		

Social History	Yes	No
Do you smoke?		
If yes, do you smoke every day?		
If no, have you ever smoked?		
Do you use recreational drugs?		
Do you drink alcohol?		
Are you currently pregnant or nursing?		

Who is your employer? _____

What is your occupation? _____

Patient Review of Health (current & previous)	Yes	No
Constitution (Fever, Weight Gain/Loss)		
Cardiovascular/Vascular (Diabetes, HBP, Stroke)		
Ear, Nose, Throat, Mouth (Allergies, Sinus Issues)		
Respiratory (Asthma, Bronchitis, Emphysema)		
Gastrointestinal (Diarrhea, Constipation)		
Genitourinary (Genitals, Kidney, Bladder Issues)		
Musculoskeletal (Arthritis, Joint/Muscle Pain)		
Integumentary (Skin Problems)		
Neurological (Headaches, Migraines, Seizures)		
Psychiatric (Mental/Emotional Problems)		
Endocrine (Thyroid/Other Gland Problem)		
Hematologic/Lymphatic (Anemia, Bleeding Issues)		
Allergic/Immunologic (Allergy)		

Medication Allergies _____

_____

Medications – Please list **ALL** current medications.

(Prescriptions, over-the-counter, vitamins, supplements, contraceptives, etc.)

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