MEDICAL HISTORY — CONFIDENTIAL

Name_____What name do you prefer to be called_____Date_____

Address_____City_____State_____Zip_____Birthdate_____

Home phone_____Work phone_____Cell phone_____

Occupation_____Employer_____If Student: Grade & School_____

Name & Phone # to contact if Emergency_____SS#_____

Name of Parent or Spouse_____REFERRED BY_____

Name, Address and Phone # of Personal Physician_____

Name of VISION Insurance Name of MEDICAL Insurance Name of Primary member of plan

PERSONAL HEALTH HISTORY: Please circle if **you** currently have or previously had any of the following: Y = YES N = NO

Heart Disease	Y N	Thyroid Disease	Y N	Kidney Disease	Y N	Stroke	Y N	Eye Injury / Surgery	Y N	Lazy Eye	Y N
Diabetes	Y N	Lupus	Y N	Cancer	Y N	Seizures	Y N	Glaucoma	Y N	Cataracts	Y N
High Blood Pressure	Y N	Crohn's Disease	Y N	Arthritis	Y N			Macular Degeneration	Y N		

Are you allergic to any medications? Y N If yes, please explain:_____

List all medications you currently take including vitamins, over-the-counter medicine, etc. _____

_____

_____

Are You Pregnant or Nursing? Y N

List any major injuries, surgeries or hospitalizations you have had: _____

WHEN WAS YOUR LAST EYE EXAM? _____

Do you wear glasses? Y N How old are your current glasses? _____ Do you think your vision has changed? Y N

Do you wear contacts? Y N ____Disposable ____Extended Wear ____Hard/Gas Permeable Do your lenses feel dry after hours of wear? Y N

FAMILY HISTORY OF: If yes, please indicate WHICH family member by: M = Mother F= Father S= Sibling G= Grandparent A= Aunt/Uncle

Heart Disease	Y_____ N	Thyroid Disease	Y_____ N	Kidney Disease	Y_____ N	Blindness	Y_____ N	Glaucoma	Y_____ N		
Diabetes	Y_____ N	Lupus	Y_____ N	Cancer	Y_____ N	Crossed or lazy eye	Y_____ N	Macular degeneration	Y_____ N		
High Blood Pressure	Y_____ N	Arthritis	Y _____ N	Other:				Cataract	Y_____ N		

REVIEW OF SYSTEMS: Please circle if **you** currently have or previously had any of the following:

EYES: Blurred Vision	Y N	Distorted Vision	Y N	Glare	Y N	Gritty Feeling	Y N	Redness	Y N	Mucus Discharge	Y N
Double Vision	Y N	Loss of side vision	Y N	Light Sensitivity	Y N	Tearing	Y N	Itchy Eyes	Y N	Chronic Infections	Y N
Sudden Vision Loss	Y N	Flashes / Floaters	Y N	Tired Eyes	Y N	Burning	Y N	Dry Eyes	Y N	Eye Pain	Y N

GASTROINTESTINAL:
Diarrhea Y N
Constipation Y N

LYMPH / BLOOD:
Anemia Y N
Bleeding Problems Y N

EAR / NOSE / THROAT:
Allergies Y N
Hay Fever Y N
Runny Nose Y N
Post Nasal Drip Y N
Dry Mouth/ Throat Y N

CARDIO-VASCULAR:
Chest Pain Y N
Blood Clots Y N
High Blood Pressure Y N

PSYCHIATRY: Y N

ALLERGIC: Y N

SKIN DISORDER:
Eczema Y N

NEUROLOGICAL:
Headache Y N
Migraines Y N
Seizures Y N

CONSTITUTIONAL:
Chronic Fever Y N
Weight Loss/Gain Y N

GENITOURINARY:
Kidneys Y N
Bladder Y N
Genitalia Y N

BONES / JOINTS:
Joint Pain Y N
Muscle Pain Y N
Rheumatoid Arthritis Y N

RESPIRATORY:
Asthma Y N
Emphysema Y N

If answered yes, please explain if necessary _____

_____

SOCIAL HISTORY: Does your vision limit any of your preferred daily activities (____driving ____reading ____work ____sports ____knitting, ect.)? Y N

Do you participate in sports? Y N If so, which ones_____

Do you have any hobbies? Y N If so, please list_____

Do you smoke? Y N If so, how much Do you drink alcohol? ___No ___Rare ___Social ___Weekends ___Daily

ACKNOWLEDGEMENT: I acknowledge that I have received, and/or read, and understand the policy of Bensenville Eye Care Notice of Privacy Practices

Signature: Date: Reviewed by Dr. Date: