RELIANT MEDICAL GROUP
Part of OptumCare®

Eye Services Patient History Form

PLEASE PRINT CLEARLY

Reason For Visit: ____

Occupation ____

If you are **not** a Reliant Medical Group patient, do you have any allergies to medications?
____
____

If you are **not** a Reliant Medical Group patient, please list all current medications:
____
____
____

Do you smoke? Yes No

If yes, how many packs/how much per day? ____ How many years? ____ If former smoker, year quit ____

Have you ever used smokeless tobacco? Yes No

Do you drink alcohol? Yes No If yes, how much per week? ________________________

Do you use recreational drugs? Yes No If yes, what and for how long? ________________

Do you drive? Yes No

Patient Eye History

	YES	NO		YES	NO		YES	NO
Flashes	○	○	Diabetic Retinopathy	○	○	Macular Degeneration	○	○
Floaters	○	○	Lattice Degeneration	○	○	Glaucoma	○	○
Injury	○	○	Retinal Detachment	○	○	Ocular Hypertension	○	○
Surgery	○	○	Contact Lens Wearer	○	○	Color Vision Deficiency	○	○
			Amblyopia	○	○	Other	○	○

~ PLEASE TURN OVER ~

Family Medical History

Do any of your family members (parents, grandparents or siblings) have the following conditions?

	YES	NO	Which family member?
Glaucoma	○	○	
Macular Degeneration	○	○	
Retinal Detachment	○	○	
Diabetes	○	○	
High Blood Pressure	○	○	
Other Significant Eye Issues	○	○	

Medical History

Since many health issues affect your eyes, please tell us about your medical history.

Do you currently have or ever had any of the following OR taken medications for:	YES	NO	Condition
Significant Eye Issues	○	○	
Integumentary (skin) including Rosacea	○	○	
Neurologic including headaches, migraines, multiple sclerosis	○	○	
Diabetes	○	○	
Thyroid / or Other	○	○	
Ears / Nose / Throat	○	○	
Respiratory including Asthma or COPD	○	○	
Vascular / Cardiovascular including High Blood Pressure or High Choleste	○	○	
Gastrointestinal including Crohn's Disease	○	○	
Kidney / Bladder / Urinary	○	○	
Bones / Joints / Muscles including Rheumatoid Arthritis	○	○	
Lymphatic / Hematologic	○	○	
Allergic / Immunologic	○	○	
Psychiatric	○	○	
Chronic infections including HIV, Hepatitis, Lyme Disease or TB	○	○	
Other significant medical issues	○	○	
Women only: Are you pregnant or nursing?	○	○	

Contact Lens Patients Only

Are you wearing Contact Lens from a Reliant Medical Eye Services Rx? If not, what is the brand/power/base curve/lens diameter?	Yes No
How many hours a day do you typically wear your contact lenses?	How many days per week?
How many hours have you worn your contact lenses today?	
Do you ever sleep in your contact lenses?	
How often do you replace your contact lenses?	
Which brand of contact lens solution do you use?	
How old are the contacts you are currently wearing?	

A contact lens evaluation is required annually to renew your contact lens prescription. The evaluation may not be covered by your insurance company and will result in a $55.00 charge.