

Visual Department Patient History Form

PLEASE PRINT CLEARLY

Reason For Visit: _____

Occupation _____

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

If you are **not** a Southboro 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
Injury	<input type="radio"/>	<input type="radio"/>	Diabetic Retinopathy	<input type="radio"/>	<input type="radio"/>	Macular Degeneration	<input type="radio"/>	<input type="radio"/>
Surgery	<input type="radio"/>	<input type="radio"/>	Lattice Degeneration	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>
Flashes	<input type="radio"/>	<input type="radio"/>	Retinal Detachment	<input type="radio"/>	<input type="radio"/>	Ocular Hypertension	<input type="radio"/>	<input type="radio"/>
Floater	<input type="radio"/>	<input type="radio"/>	Contact Lens Wearer	<input type="radio"/>	<input type="radio"/>	Color Vision Deficiency	<input type="radio"/>	<input type="radio"/>
Cataracts	<input type="radio"/>	<input type="radio"/>	Amblyopia	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>

~ 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	<input type="radio"/>	<input type="radio"/>	_____
Macular Degeneration	<input type="radio"/>	<input type="radio"/>	_____
Retinal Detachment	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	_____
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	_____
Other Significant Eye Issues	<input type="radio"/>	<input type="radio"/>	_____

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
Integumentary (skin) including Rosacea	<input type="radio"/>	<input type="radio"/>	_____
Neurologic including headaches, migraines, multiple sclerosis	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	_____
Thyroid / or Other	<input type="radio"/>	<input type="radio"/>	_____
Ears / Nose / Throat	<input type="radio"/>	<input type="radio"/>	_____
Respiratory including Asthma or COPD	<input type="radio"/>	<input type="radio"/>	_____
Vascular / Cardiovascular including High Blood Pressure or High Cholesterol	<input type="radio"/>	<input type="radio"/>	_____
Gastrointestinal including Crohn's Disease	<input type="radio"/>	<input type="radio"/>	_____
Kidney / Bladder / Urinary	<input type="radio"/>	<input type="radio"/>	_____
Bones / Joints / Muscles including Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	_____
Lymphatic / Hematologic	<input type="radio"/>	<input type="radio"/>	_____
Allergic / Immunologic	<input type="radio"/>	<input type="radio"/>	_____
Psychiatric	<input type="radio"/>	<input type="radio"/>	_____
Chronic infections including HIV, Hepatitis, Lyme Disease or TB	<input type="radio"/>	<input type="radio"/>	_____
Other significant medical issues	<input type="radio"/>	<input type="radio"/>	_____
Women only: Are you pregnant or nursing?	<input type="radio"/>	<input type="radio"/>	_____

Contact Lens Patients Only

Are you wearing Contact Lens from a Southboro Medical Visual Services Rx? Yes No
 If not, what is the brand/power/base curve/lens diameter?

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.