

PHOENIXVILLE EYE CARE SPECIALISTS

**PATIENT MEDICAL HISTORY FORM**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for Visit? \_\_\_\_\_

**EYE HISTORY**

Have you ever had or do you have cataracts? Yes \_\_\_ No \_\_\_  
glaucoma (pressure in the eye)? Yes \_\_\_ No \_\_\_  
lazy eye? Yes \_\_\_ No \_\_\_  
retinal detachment? Yes \_\_\_ No \_\_\_  
macular degeneration? Yes \_\_\_ No \_\_\_  
diabetic retinopathy? Yes \_\_\_ No \_\_\_  
other eye problems? Yes \_\_\_ No \_\_\_

if YES, what? \_\_\_\_\_

Have you ever had eye surgery? Yes \_\_\_ No \_\_\_ if YES, what? \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_ How old are your present glasses? \_\_\_\_\_

Do you have prisms? Yes \_\_\_ No \_\_\_ Do you wear contact lenses? \_\_\_\_\_

**MEDICAL HISTORY**

Have you ever had or do you have diabetes? Yes \_\_\_ No \_\_\_  
high blood pressure? Yes \_\_\_ No \_\_\_  
other illness? Yes \_\_\_ No \_\_\_

if YES, what? \_\_\_\_\_

Previous surgery? Yes \_\_\_ No \_\_\_ if Yes, what? \_\_\_\_\_

Do you take any medications? Yes \_\_\_ No \_\_\_ if YES, what? \_\_\_\_\_

Are you allergic to any medications? Yes \_\_\_ No \_\_\_ if YES, what? \_\_\_\_\_

**FAMILY HISTORY**

Has any blood relative ever had diabetes? Yes \_\_\_ No \_\_\_  
glaucoma? Yes \_\_\_ No \_\_\_  
cataracts? Yes \_\_\_ No \_\_\_  
lazy eye? Yes \_\_\_ No \_\_\_  
macular degeneration? Yes \_\_\_ No \_\_\_  
blindness or other eye trouble? Yes \_\_\_ No \_\_\_

if YES, what? \_\_\_\_\_