Name: _____

DOB : _____

Enfield Eyecare Associates

Medical History – Check all that apply

Address: _____

_____

- □ **No current problems or disability**
- □ Alzheimer's disease
- □ Anemia
- □ Angina
- □ Anxiety
- □ Asthma
- □ Autoimmune disease
- □ Bell's palsy
- □ Breast cancer
- □ Bronchitis
- □ Cancer
- □ Cardiac arrest
- □ Carotid artery occlusion
- □ Chronic gouty arthritis
- □ Chronic obstructive lung disease
- □ Chronic pain
- □ Chronic sinusitis
- □ Congestive heart failure
- □ Coronary artery disease
- □ Crohn's disease
- □ Dementia
- □ Depression
- □ Diabetes – diet controlled
- □ Diabetes – gestational
- □ Diabetes mellitus type 1
- □ Diabetes mellitus type 2
- □ Diverticulitis
- □ Down's syndrome
- □ Eating disorder
- □ Eczema
- □ Emphysema
- □ Gastroesophageal reflux disease
- □ Hashimoto's disease
- □ Headache disorder
- □ Heart disease
- □ Hepatitis type A
- □ Hepatitis type B
- □ Hepatitis type C
- □ High cholesterol
- □ HIV
- □ Hypertension
- □ Hyperthyroidism
- □ Hypoglycemia
- □ Hypothyroidism
- □ Kidney disease
- □ Leukemia
- □ Lyme disease
- □ Menopausal syndrome
- □ Mental disorder
- □ Migraines
- □ Multiple sclerosis
- □ Muscular dystrophy
- □ Osteoporosis
- □ Pancreatitis
- □ Pneumonia
- □ Polymyalgia rheumatica
- □ Postmenopausal
- □ Primary fibromyalgia
- □ Rheumatoid arthritis
- □ Sarcoid
- □ Sexually transmitted disease
- □ Sinusitis
- □ Sjogren's syndrome
- □ Sleep apnea
- □ Systemic lupus erythematosus
- □ TIA
- □ Tuberculosis
- □ Ulcerative colitis

Who is your Primary Care Physician (PCP)? _____

How long has it been since your last visit to your PCP?

- □ Less than 1 week
- □ Less than 1 month
- □ 6 months
- □ 1 year
- □ 18 months
- □ 2 years
- □ 3 years
- □ More than 3 years

What was the reason for your last visit? _____

Vitals

Height in inches: _____ Weight in pounds: _____

(example: 5 feet = 60 inches)

Please list any **medications** you are currently taking & the dosages below:

_____

_____

_____

_____

_____

_____

Please list any **allergies** to medications below:

_____

_____

Health Review – Check all that CURRENTLY apply

Constitutional (physical state)

□ **Negative**
□ Appetite – decreased
□ Appetite – increased
□ Chills
□ Fatigue
□ Fever
□ Insomnia
□ Itching
□ Lethargic
□ Light headedness
□ Loss of sensation
□ Mood swings
□ Muscle cramps
□ Rash
□ Sleep – excessive
□ Sleep – change in pattern
□ Weakness
□ Weight – sudden gain
□ Weight – sudden loss
□ Other: _____

Cardiovascular

□ **Negative**
□ Chest pain
□ Difficulty breathing while sleeping
□ Dizziness
□ Faintness
□ Irregular heart beat
□ Loss of consciousness
□ Lower leg edema
□ Pacemaker
□ Shortness of breath
□ Varicose veins
□ Other: _____

Ears, Nose, Mouth, Throat

□ **Negative**
□ Bleeding gums
□ Chronic colds
□ Chronic sinusitis
□ Chronic strep
□ Dentures
□ Ear pain
□ Frequent nose bleeds
□ Hearing loss
□ Mouth sores
□ Nasal congestion
□ Pain with swallowing
□ Ringing in ears
□ Sinus pain
□ Sore throat
□ Toothache
□ Vertigo
□ Other: _____

Respiratory System (Breathing/Lungs)

□ **Negative**
□ Chest pain
□ Coughing
□ Shortness of breath
□ Sleep apnea
□ Wheezing
□ Other: _____

Gastrointestinal System (Stomach/Intestines)

□ **Negative**
□ Abdominal pain
□ Anorexia
□ Bloating
□ Change in appetite
□ Constipation
□ Diarrhea
□ Difficulty swallowing
□ Heartburn
□ Indigestion
□ Irritable bowel syndrome (IBS)
□ Nausea/vomiting
□ Reflux
□ Unintentional weight loss
□ Other: _____

Genitourinary System (Reproduction/Urinary)

□ **Negative**
□ Frequent urination
□ Incontinence
□ Irregular periods
□ Needing to go in the middle of the night
□ Painful urination
□ Terminal dripping
□ Vaginal discharge
□ Other: _____

Musculoskeletal System (Bones/Ligaments/Muscles)

□ **Negative**
□ Arthritis
□ Back pain
□ Joint pain
□ Joint swelling
□ Muscle pain
□ Stiffness
□ Other: _____

Integumentary System (Skin/Hair/Nails)

□ **Negative**
□ Bruising
□ Changes in nails/hair
□ Changes in skin color
□ Eczema
□ Excessive dryness
□ Excessive sweating
□ Itching
□ Lesions
□ Tumors
□ Rash
□ Other: _____

Neurological

□ **Negative**
□ Changes in hearing
□ Changes in sight
□ Changes in smell
□ Changes in taste
□ Dizziness
□ Fainting
□ Headache
□ Limb weakness
□ Migraines
□ Numbness
□ Pins and needles
□ Poor balance
□ Seizures
□ Speech problems
□ Other: _____

Psychiatric

□ **Negative**
□ Anxious
□ Confused
□ Depression
□ Disoriented
□ Easily agitated
□ Mood swings
□ Nervousness
□ Memory loss
□ Other: _____

Endocrine Systems (Hormonal)

□ **Negative**
□ Depression
□ Excessive thirst
□ Headache
□ Mood swings
□ Palpitations
□ Tired
□ Tremors
□ Unexplained weight loss
□ Visual disturbances
□ Other: _____

Hematologic/Lymphatic System (Blood/Circulation)

□ **Negative**
□ Anemia
□ Excessive bleeding
□ History of blood transfusion
□ Lymph node tenderness
□ Other: _____

Allergic/Immunologic

□ **Negative**
□ Animal allergy
□ Bee sting allergy
□ Food allergy
□ Itchy/teary eyes
□ Material allergy
□ Medication allergy
□ Runny nose
□ Other: _____

Family History

□ **Family history is unknown**

	Mother	Father	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Brother	Sister
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Cardiovascular Disease	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Endocrine Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐

	Mother	Father	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Brother	Sister
Amblyopia	☐	☐	☐	☐	☐	☐	☐	☐
Blindness/Vision Loss	☐	☐	☐	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐
Malignant Tumor of Eye	☐	☐	☐	☐	☐	☐	☐	☐
Retina Disease	☐	☐	☐	☐	☐	☐	☐	☐
Retinitis Pigmentosa	☐	☐	☐	☐	☐	☐	☐	☐
Strabismus	☐	☐	☐	☐	☐	☐	☐	☐

Emergency Contact:

Name: _____ Relationship: _____ Phone Number: _____

Ocular History

Do you wear glasses and/or contact lenses?

- □ Glasses
- □ Contacts

Do you wear glasses and/or contact lenses due to any of the following?

- □ Distance
- □ Both
- □ Near

Do you have any of the following conditions?

- ☐ Amblyopia (Lazy Eye)
- ☐ Blepharitis
- ☐ Blurred Vision
- ☐ Burning eyes
- ☐ Cataract
- ☐ Cataract Removed
- ☐ Chalazion (Stye)
- ☐ Computer vision problems
- ☐ Corneal Abrasion
- ☐ Corneal Scar
- ☐ Diabetic Retinopathy
- ☐ Distorted Vision/Haloes
- ☐ Double Vision
- ☐ Dry Eye
- ☐ Eye Pain
- ☐ Flashes of light
- ☐ Floaters
- ☐ Foreign body sensation
- ☐ Glaucoma
- ☐ Glare/Light Sensitivity
- ☐ Itchy eyes
- ☐ Keratoconus
- ☐ Loss of vision
- ☐ Macular Degeneration
- ☐ Red eyes
- ☐ Retinal Detachment
- ☐ Retinal Disorder
- ☐ Retinal Tear
- ☐ Tearing/Watering
- ☐ Uveitis

List any other eye disorders: _____

Contact Lens History

What type of lenses do you wear?

- □ 1 month disposable
- □ 2 week disposable
- □ Daily disposable
- □ Gas permeable
- □ Sleep in lenses

On average, how many hours a day do you wear your contacts? _____

How often do you replace your lenses? _____

What product do you use to clean/store your lenses? _____

Social History

What is your occupation? _____

What are your work duties/status?_____

What is your smoking status?

- □ Current every day smoker
- □ Current some day smoker
- □ Former smoker
- □ Never smoker

Do you drink alcohol?

- □ Non-drinker
- □ Social drinker
- □ Light drinker – 1-2u/day
- □ Moderate drinker – 3-6u/day
- □ Heavy drinker – 7-9u/day

Do you misuse/abuse drugs or medications? Check all that apply.

- □ No
- □ Recreational drug abuser
- □ Cannabis
- □ Cocaine
- □ Crack
- □ Heroin
- □ LSD
- □ Methamphetamine
- □ Oxycontin
- □ Speed
- □ Other: _____