Beacon Family Eye Care Patient History

Todays Date: _____ How did you hear about us?: _____
Patient Name: _____ Date of Birth: _____ Age: _____ Gender: _____
Phone: (home) _____ (work) _____ (cell) _____

Primary Care Physician
Name: _____ Address: _____ Phone: _____
Other healthcare providers you wish us to communicate with
Name: _____ Address: _____ Phone: _____
Name: _____ Address: _____ Phone: _____
Name: _____ Address: _____ Phone: _____

Were you referred by a doctor for this visit? Yes / No If yes, who: _____
What medical/visual problem brings you here? _____

Eye History (circle)
Do you wear glasses? **Yes No**
Are you looking for new glasses prescription? **Yes No**
Do you wear contact lenses? **Yes No**
If YES, are you happy with your current lenses? **Yes No**
Are you looking for a new contact lens prescription? **Yes No**

Have you ever been told you have an eye disease such as amblyopia, "lazy eye", strabismus, macular degeneration, retinal detachment, cataracts, or glaucoma? **Yes No** If YES, what?_____
_____
Have you ever had eye surgery or an eye injury? **Yes No** If YES, what and when? _____
_____
Do you currently use eye drops? **Yes No** If Yes, which drops and how often do you use them? _____
_____

Medical History
Have you recently been vaccinated for Influenza? Yes No
Have you ever been vaccinated for Pneumonia? Yes No

Have you ever been diagnosed with any of the following medical conditions (check those that apply)?

	Yes	No		Yes	No		Yes	No
Diabetes	___	___	High Blood Pressure	___	___	Heart Disease	___	___
High Cholesterol	___	___	Stroke	___	___	Numbness/Weakness/Paralysis	___	___
Parkinson's	___	___	Alzheimer's	___	___	Intestinal disease	___	___
Cerebral palsy	___	___	Autoimmune disease	___	___	Arthritis	___	___
Headache/migraine	___	___	Seasonal allergies	___	___	Asthma/COPD/Emphysema	___	___
Depression/anxiety	___	___	Thyroid	___	___	Cancer	___	___
Skin disorders	___	___	Kidney	___	___	Blood disorder	___	___

Are there any conditions/illnesses you have been treated for that are not listed on this form? Yes No
If yes, please specify: _____
_____

TURN OVER TO 2nd PAGE

Medications

Please list all medication you are currently taking:

___ I do not take any medications, over the counter supplements, or vitamins.

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies you have to medications:

___ I do not have allergies to medications

_____	_____	_____	_____

Please list all surgeries you have had:

___ I have not had any surgeries in my lifetime

_____
_____
_____
_____

Family History

M=Mother F=Father S=Sibling G=Grandparent

	Yes	No	Relationship to patient
Glaucoma	_____	_____	_____
Macular Degeneration	_____	_____	_____
Retinal Disease	_____	_____	_____
Strabismus	_____	_____	_____
Amblyopia (“lazy eye”)	_____	_____	_____
High blood pressure	_____	_____	_____
Heart disease	_____	_____	_____
Diabetes	_____	_____	_____
Lupus	_____	_____	_____
Arthritis	_____	_____	_____
Thyroid	_____	_____	_____
Cancer	_____	_____	_____

Are ther any conditions/illnesses for family members not listed on this form? Yes No

If YES, please specify: _____

_____

Social History

Occupation: _____

Martial Status: _____

Do you smoke (circle)? Yes No Amount: _____

Do you drink alcohol (circle)? Yes No Amount: _____

Do you have a history of substance abuse (circle)? Yes No