JAMES DUGAS, OD
PATIENT MEDICAL HISTORY FORM

Patient Name_____DOB_____

Date_____

PATIENT OCULAR HEALTH HISTORY
Reason for today's exam?_____
Date of last eye exam _____
Name of previous eye doctor_____

Eyewear History
Current Eyeglasses: __None __Single Vision __Bifocals __Progressives __Reading Only
Problems?_____

Contact Lens History
Do you wear contact lenses? __Y __ N
If so, what kind/brand_____
Disinfecting solution_____

Are you interested in contact lenses, but have never worn them? __ Y __N

Do you work on a computer? __Y __N If so, how many hours per day?_____

What hobbies or sports do you participate in that may need special vision correction?
_____

PATIENT MEDICAL HISTORY
List any medications being taken (including birth control, aspirin, over the counter, and home remedies) _____
_____

List any allergies to medications and any other allergies
_____

List any major injuries, surgeries, or hospitalizations_____

Females Only: Are you pregnant or nursing?_____

Patient Name_____DOB_____

FAMILY MEDICAL HISTORY

List any blood relative in your family (list condition and relative) that has any history of Diabetes, Hypertension, Heart Disease, Cancer (type), Arthritis, Lupus, Kidney problems, Thyroid problems, or Stroke_____

_____

_____

PATIENT SOCIAL HISTORY

Insurance companies require us to inquire about the following.

__ I prefer to discuss my social history with my doctor.

Tobacco: __None __Occasional __Often

Alcohol: __None __Occasional __Often

Un-prescribed or illegal substance: _____

PATIENT'S MEDICAL HISTORY

Do you currently have any of the following medical conditions? __None

Circle or check any that apply and date of diagnosis.

General: __Fever __Weight Loss __Weight Gain __Fatigue

Ears, Nose, Throat: __Allergies __Sinus __Cough __Dry Mouth __Throat

Endocrine: __Diabetes __Thyroid

Gastrointestinal: __Ulcer __Acid Reflux __Crohn's __Irritable Bowel Syn (IBS)

Skin: __Psoriasis __Rosacea

Neurological: __Headaches __Migraines __Seizures __Multiple Sclerosis

Psychiatric: __Depression __Anxiety __Insomnia

Respiratory: __Asthma __COPD __Sleep Apnea

Urinary: __Kidney Disease __Bladder

Cardiovascular: __High Blood Pressure __Heart Surgery __High Cholesterol

Other: __HIV+ __AIDS

PATIENT'S EYE HISTORY

List any previous eye condition that you have been diagnosed with and date

_____

List any eye surgery and date such as LASIK, Retinal Detachment, Cataract (which eye)

_____

Patient/ Representative Print_____

Patient/ Representative Sign_____ Date_____