Dr.'s Initial's: ________

Hayes Eye Center
Patient Medical History

Name: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. ____________________

Today's Date: ____________ **Date of Birth:** ____________ **Gender:** ☐Male ☐ Female

Date of Last Eye Exam: ____________ **Location of Last Eye Exam:** ____________

Date of Last Physical: ____________ **Physician's Name:** ____________

Medications (prescription, over-the-counter, supplements, and any eye drops. If you cannot remember the name you may list the use of the medication, i.e. "blood pressure".):

____

____

____

List any drug allergies: ☐ None ____________________

Do you wear glasses? ☐Yes ☐No **Do you wear contact lenses?** ☐Yes ☐No

Are you currently experiencing any of the following EYE problems?

☐Blurred vision at distance
☐Trouble reading up close
☐Burning
☐Itching
☐Redness
☐Dryness
☐Eye Pain
☐Foreign Body Sensation
☐Double Vision
☐Eye turn
☐Eye lid concerns
☐Flashes of light
☐Floating spots
☐Other: ____________

Please list any eye injuries and/or surgeries: ____________________

Do you currently have medical conditions in any of the following categories

☐ Diabetes
☐ High Blood Pressure
☐ Heat Disease
☐ Respiratory
☐ Thyroid
☐ Ear/Nose/Throat
☐ Headache/Migraine
☐ Neurological
☐ Muscles/Bones/Joints
☐ Gastrointestinal
☐ Kidney/Bladder
☐ Reproductive
☐ Autoimmune
☐ Skin
☐ Allergies
☐ General (fatigue, weight loss/gain)

☐Other: (please describe): ____________________

Family history (please indicate relationship to person(s) to patient):

☐Glaucoma: ____________
☐Macular Degeneration: ____________
☐Eye turn: ____________
☐Blindness: ____________
☐Diabetes: ____________
☐High Blood Pressure: ____________
☐Thyroid Disease: ____________
☐Other: ____________

Current Occupation: ____________ **Hobbies:** ____________

Do you drink alcohol? ☐Yes ☐No If yes, how much per day? ____________

Do you smoke? ☐Yes ☐No If yes, how much per day? ____________

Do you use recreational drugs? ☐Yes ☐No If yes, please list: ____________

Are you pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No