The Franklin Eye Center

Patient Medical History Form

Date: ____

Name: ______________________________________

Date of Birth: _______________**Age:** _____________

Medical Doctor: ________________________________

What is the main reason for your visit today?

____

____

Do you have any of these eye symptoms?
(Please check all that apply)

□ Blurred distance vision □ Red Eyes
□ Blurred reading vision □ Eye Pain
□ Constant double vision □ Dry Eyes
□ Flashing Lights or Floaters
□ Foreign Body Sensation
□ Eye Mattering or tearing
□ Itching or Burning Eyes

Past Ocular History (Please check all that apply)
□ Amblyopia (Lazy Eye) □ Cataracts
□ Macular Degeneration □ Glaucoma
□ Retinal Disorders □ Eye Surgery
□ Strabismus (Eye Turn) □ Eye Injury

Have members of your family had any of these eye diseases? (Parents, Siblings, Grandparents)
(Please check all that apply)
□ Glaucoma □ Cataracts
□ Macular Degeneration □ Glaucoma
□ Retinal Disorders □ Poor Vision
□ Diabetic Eye Disease or Diabetes
□ Blindness

Please list any surgeries you have had:

Type of Surgery	Year

Have you had any of these conditions?
(Please check all that apply)
□ Diabetes x _________ years
□ Cancer Type : ______________________
□ High Blood Pressure □ Allergies
□ High Cholesterol □ Asthma
□ Shortness of Breath □ Stroke
□ Emphysema □ COPD
□ Multiple Sclerosis □ AIDS/HIV
□ Congestive Heart Failure □ MRSA
□ Herpes Zoster / Shingles □ Herpes Simplex
□ Hepatitis A / B / C □ Migraines
□ Thyroid Disease □ Sjogrens
□ Rheumatoid Arthritis □ Bleeding Disorder
□ Bell's Palsy □ Dementia
□ Fibromyalgia □ Rosacea
□ Irregular Heart Beat □ Graves Disease
□ Seizures □ Anxiety
□ Bipolar □ Depression

Cardiovascular / Circulatory

Do you have a Pace Maker? □ YES □ NO

Do you have a Defibrillator? □ YES □ NO

Social History – Please indicate your past and present experience with the following:

Alcohol: ______ drinks per week
Coffee/Tea: _____ drinks per day
Smoking: _____ cigarettes per day _____ years

Occupation: ____________________________________

Hobbies: ______________________________________

What type of eyeglass lenses do you wear?
□ Single Vision □ Bifocal □ Progressive
□ None

What type of contact lenses do you wear?
□ Soft □ Bifocal □ Gas Permeable
□ None

Would you like to wear contact lenses? □ YES □ NO