MITCHELL EYE CARE

Patient Medical History Form

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Name:

_____

Patient Eye History

Date of Last Eye Exam:

_____

By Whom?

_____

Have you had any eye-related surgeries of any kind?
☐ Yes ☐ No

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Blurry Vision
☐ Burning
☐ Cataracts
☐ Corneal Abrasions
☐ Crossed eye/Eye turn
☐ Double Vision
☐ Eye Infections
☐ Eye Injury
☐ Flash of light
☐ Floaters/Spots
☐ Glaucoma
☐ Grittiness
☐ Headaches
☐ Iritis/Uveitis
☐ Itchiness
☐ Lazy Eye
☐ Macular Degeneration
☐ Occasional dryness
☐ Retinal Detachment
☐ Sunlight Sensitivity
☐ Tearing
☐ Trouble seeing at night
☐ Uncomfortable glasses
☐ Other

Family Medical/Eye History

Do you have a family medical history of any of the following? (check all that apply and indicate mother or father's side):

		Relationship (Mother's or Father's side)
Blindness	☐	
Cataracts	☐	
Corneal Problems	☐	
Diabetes	☐	
Glaucoma	☐	
Heart Disease	☐	

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MITCHELL EYE CARE

Patient Medical History Form, Continued

Patient Medical History

Name of Family Physician:

_____

Name of Physician's clinic:

_____

Date of Last Physical Check-Up:

_____

Height:_____Weight:_____

Current Medications (Rx or Over-The-Counter)

(List name of medications, including eye drops, vitamins & birth control pills, dosages, and frequency:_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies to medications? ☐ Yes ☐ No

If so, what medications?

_____

_____

_____

Patient Medical History, Cont.

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Fevers	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Throat Infections	☐	☐
Thyroid	☐	☐
Unusual weight losses/gains	☐	☐