EYE CARE THAT EXCEEDS YOUR EXPECTATIONS

www.westshoreeyecare.com | (231) 843-4117

PATIENT MEDICAL HISTORY AND INFORMATION

Please print and complete the form below to provide us with up to date information to give you the best eye care possible. Please be aware that this information is strictly confidential and all is required as part of your medical record.

Demographics

Date of Birth: ______ Name: ______ Address: ______ ______ Email: ______ Home: ______ Work: ______ Cell: ______ Height: ______ Weight: ______ Last 4 digits of SSN: ______ Spouse or Parents Name: ______	How did you hear about West Shore Eye Care? Friend (Who?) ______ Doctor (Who?) ______ Other: ______ Marital Status: ______ ☐ Single ☐ Married ☐ Other

Lifestyle History

Current Occupation/Student: Employer/School:
Do you use an Ipad/Tablet/Computer? ☐ Yes ☐ No
Do you have Sunglasses? ☐ Yes, Prescription ☐ Yes, OTC ☐ Transitions ☐ Clip Ons ☐ No
Are you interested in LASIK? ☐ Yes ☐ No ☐ Already had it
Do you wear Contacts? ☐ Yes, Everyday ☐ Yes, <5 days/week ☐ Yes, Occasionally ☐ No, I used to ☐ No, Never
How often do you throw your contacts out? ☐ Dly ☐ Wkly ☐ 2 Weeks ☐ Mthly ☐ When they bother me ☐ Other
Name (Brand) of contacts: ______
What do you NOT like about your glasses? ______
Do you exercise regularly? ______
What hobbies and interests do you participate in? ______

Medical and Eye History

Please list any medications you are currently taking (including vitamins):
______
______
______
Please list any allergies you may have: ______
Are you currently pregnant or nursing: ☐ Yes ☐ No

Are you currently under the care of an Ophthalmologist? ☐ Yes ☐ No
Please provide the name of your Primary Care Physician: ______________________________

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Do You Experience Any of The Following Eye Symptoms?

☐ Dry Eyes	☐ Floaters
☐ Blurred Vision	☐ Excessive Watering
☐ Eyestrain	☐ Flashes
☐ Poor Night Time Vision	☐ Itching
☐ Headaches	☐ Loss of Vision
☐ Double Vision	☐ Redness
☐ Glare/Light Sensitivity	

Have you Been Diagnosed With Any of These Conditions?

☐ Amblyopia (lazy eye)	☐ Strabismus (eye turn)
☐ Infection of the Eye	☐ Diabetic Retinopathy
☐ Glaucoma	☐ Corneal Ulcers
☐ Dry Eye Syndrome	☐ Color Blindness
☐ Cataract	☐ Keratoconus
☐ Blepharitis	☐ Eye Injury
☐ Macular Degeneration	☐ Eye Surgery

Do You Have the Following Conditions?

☐ Diabetes	☐ Heart Conditions
☐ High Blood Pressure	☐ Respiratory (asthma)
☐ High Cholesterol	☐ Skin (rosacea, eczema)
☐ Arthritis	☐ Neurological (migraines)
☐ Lupus	☐ Mental Health
☐ Anemia	☐ Blood / Lymph
☐ Thyroid (Hyper - Hypo)	☐ Cancer
☐ Allergies	

Do You Have a Family History of:

☐ Glaucoma	☐ Eye Surgery
☐ Macular Degeneration	☐ Strabismus
☐ Blindness	☐ Keratoconus
☐ Diabetic Vision Loss	☐ Diabetes
☐ Amblyopia (lazy eye)	☐ Hypertension
☐ Retinal Detachment	☐ Heart Disease

☐ Color Blindness	

Please use this space to explain any YES answers above or to list any further information we forgot to ask: