FAMILY EYE GROUP

Medical Information Form

Patient's Name: _____ Birth Date: ____/____/____

Do you wear glasses or contact lenses? ❑ Yes ❑ No If Yes, for how long? _____

Please ✓ if any of the following apply to you and the date it first occurred:

MEDICAL PROBLEMS

Condition	Please ✓	Date
Alzheimers	❑ Yes ❑ No	
Arthritis	❑ Yes ❑ No	
Asthma/COPD/Bronchitis	❑ Yes ❑ No	
Cancer – type _____	❑ Yes ❑ No	
Diabetes – type _____	❑ Yes ❑ No	
High blood pressure	❑ Yes ❑ No	
Hepatitis/Jaundice	❑ Yes ❑ No	
Heart Disease	❑ Yes ❑ No	
Head Injury	❑ Yes ❑ No	
HIV positive/AIDS	❑ Yes ❑ No	
Kidney Disease	❑ Yes ❑ No	
Lupus	❑ Yes ❑ No	
Migraine Headaches	❑ Yes ❑ No	

Condition	Please ✓	Date
Rheumatic Fever	❑ Yes ❑ No	
Sarcoidosis	❑ Yes ❑ No	
Seizures	❑ Yes ❑ No	
Stroke	❑ Yes ❑ No	
Syphilis / Gonorrhea	❑ Yes ❑ No	
Thyroids Disease	❑ Yes ❑ No	
Tuberculosis	❑ Yes ❑ No	

Other Medical Problems (Please List)

_____
_____
_____
_____
_____

SURGICAL HISTORY

Have you had **general** surgery? ❑ Yes ❑ No

Please list:

Surgery	Date	Surgeon/Hospital

Have you had **eye** surgery? ❑ Yes ❑ No

Please list (including laser and lid surgery):

Surgery	Date	Surgeon/Hospital

MEDICATIONS *(Please List)*

Name	Dosage

Are you allergic to any medications, iodine, latex or anesthesia?
❑ Yes ❑ No If ***yes***, please list below:

_____

Do you require antibiotics prior to dental work or surgery?
❑ Yes ❑ No

FAMILY MEDICAL PROBLEMS

Do any family members have:	Please ✓	Relative
Glaucoma	❑ Yes ❑ No	
Macular Degeneration	❑ Yes ❑ No	
Diabetes	❑ Yes ❑ No	
Retinal Detachment	❑ Yes ❑ No	
Cataracts	❑ Yes ❑ No	
Amblyopia/Strabismus	❑ Yes ❑ No	
Other (list): _____		

SOCIAL HISTORY

Are you pregnant?	❑ Yes ❑ No
Do you smoke?	❑ Yes ❑ No
Do you drink alcohol?	❑ Yes ❑ No
Do you drink caffeine?	❑ Yes ❑ No
Do you use illegal drugs?	❑ Yes ❑ No

This is to certify that, I the undersigned, consent to examination and treatment. This information and any photography may be used for scientific and educational purposes. I hereby authorize Family Eye Group to furnish information to my insurance carrier, employer, referring physician, or other physician concerning my treatment and/or illness. I transfer assignment of all insurance benefits to Family Eye Group for services, treatment, supplies or surgeries provided by physicians or staff. I understand that **I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.**

Patient Signature _____ **Date** _____