COMPLETE EYE CARE INC.
MEDICAL • SURGICAL • OPTICAL

# NEW PATIENT MEDICAL INFORMATION

NAME _____

DATE _____ AGE _____ BIRTHDATE _____

**HOW DID YOU HEAR ABOUT US?** _____

_____

PRIMARY CARE DOCTOR _____

## EYE HISTORY

How long since your last eye exam? _____ Do you wear glasses? _____

How old is your present prescription? _____

Do you wear contact lenses? _____ What type? _____

Have you ever had eye surgery? _____

If yes, list type and dates: _____

_____

_____

Please indicate if you have had any of the following:

| | YES | NO | COMMENTS |
|---|---|---|---|
| Loss of Vision | ☐ | ☐ | _____ |
| Double Vision | ☐ | ☐ | _____ |
| Cataract / Cataract Surgery | ☐ | ☐ | _____ |
| Glaucoma / Elevated Pressure | ☐ | ☐ | _____ |
| Floaters or Flashers | ☐ | ☐ | _____ |
| Crossed or Lazy Eye | ☐ | ☐ | _____ |
| Chronic Inflammation | ☐ | ☐ | _____ |
| Macular Degeneration | ☐ | ☐ | _____ |

## PAST MEDICAL HISTORY

List all major medical problems, hospitalizations or illnesses you have had:

_____

List all non-eye surgeries you have had in the past: _____

_____

List all medications you take: _____

_____

List any MEDICATION allergies: _____

_____ **NO KNOWN ALLERGIES** ☐

## FAMILY HISTORY

Has any relative of yours had any of the following diseases?

| Give relationship: | YES | NO | RELATIONSHIP |
|---|---|---|---|
| Blindness | ☐ | ☐ | _____ |
| Glaucoma | ☐ | ☐ | _____ |
| Macular Degeneration | ☐ | ☐ | _____ |
| Retinal Detachment | ☐ | ☐ | _____ |
| Diabetes | ☐ | ☐ | _____ |
| Other | ☐ | ☐ | _____ |

## SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Current Occupation: _____

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Previously, but quit ☐ Yes, ____ packs/day

*Reviewed by:*

Technician's Signature _____ Date _____

Physician's Signature _____ Date _____