FOREMAN Eye Associates

MEDICAL INTAKE FORM – FOREMAN EYE ASSOCIATES LLC

DEMOGRAPHICS

Name: _____ Today's Date: _____

Address: _____ Date of Birth: _____

_____ Last Eye Exam: _____

Primary Phone: _____ Occupation: _____

Email: _____ Primary Care Doctor: _____

MEDICAL HISTORY

Do you take any medications? _____ Do you have any drug allergies? _____ If yes, please list: _____

Please list medications, and doses, of all prescription and non-prescription medications and supplements: _____

_____

_____

Please list all major health issues, including but not limited to diabetes, hypertension, elevated cholesterol, heart disease, thyroid disease, autoimmune disease, inflammatory disease, kidney disease, arthritis, cancer, etc: _____

_____

Are you pregnant or nursing? _____

OCULAR HISTORY

Have you ever experienced any ocular injury? _____ If yes, please describe: _____

Have you ever had any ocular surgeries? _____ If yes, please describe: _____

Are you experiencing any of the following symptoms currently or in the past? (Please circle) *Loss of vision ~ Blurred vision ~ Distorted Vision ~ Halos ~ Loss of peripheral vision ~ Double Vision ~ Dry Eyes ~ Itchy Eyes ~ Redness ~ Burning ~ Light Sensitivity ~ Tearing ~ Glare ~ Foreign Body Sensation ~ Pain ~ Floaters ~ Flashes ~ Fatigue.*

Please describe: _____

_____

Do you wear glasses? _____ Type? _____ If yes, how old is current Rx? _____

Do you wear contacts? _____ Type? _____ If yes, how old is current Rx? _____

SOCIAL HISTORY *(Information is confidential. However, if you would prefer, you can leave this blank and discuss directly with the doctor)*

Do you drink? _____ Do you smoke cigarettes? _____ Do you use illegal drugs? _____

Have you ever had Gonorrhea, Hepatitis, HIV, syphilis, or any infectious disease? _____ If yes, describe: _____

FAMILY HISTORY

Does anyone in your family (parent, grandparent, sibling, child, aunt, or uncle) have any of the following ocular conditions? *Blindness ~ Glaucoma ~ Macular Degeneration ~ Retinal Disease ~ Cataracts ~ Crossed Eyes ~ Other.* If so, please list each condition and who has it. _____

_____

Does anyone in your family (parent, grandparent, sibling, child, aunt, or uncle) have any of the following systemic conditions? *Diabetes ~ Hypertension ~ Heart Disease ~ Kidney Disease ~ Thyroid Disease ~ Lupus ~ Cancer ~ Other.* If so, please list each condition and who has it. _____

_____

REVIEW OF SYSTEMS

Please check or circle any of the following symptoms or conditions that currently apply to you:

Fever ~ Weight Gain ~ Weight Loss ~ Headache ~ Migraine ~ Seizures ~ Thyroid Disorder ~ Allergies ~ Sinus Congestion ~ Dry Throat/Mouth ~ Asthma ~ Bronchitis ~ Emphysema ~ COPD ~ Diabetes ~ Heart Pain ~ Hypertension ~ Vascular Disease ~ Diarrhea ~ Constipation ~ Genitourinary Disorders ~ Kidney Disorder ~ Bladder Disorder ~ Prostate Disorder ~ Arthritis ~ Rheumatoid Arthritis ~ Muscle Pain ~ Joint Pain ~ Anemia ~ Bleeding Disorder ~ Anxiety ~ Depression.

Please describe any/all of the above checked, if not described in previous section: _____

_____

_____

FOR DOCTOR

I have reviewed the medical history form above. Doctor's Signature _____ Date: _____

Reviewed; Doctor's Initials & Date: _____ *Changes noted:* _____

Reviewed; Doctor's Initials & Date: _____ *Changes noted:* _____

Reviewed; Doctor's Initials & Date: _____ *Changes noted:* _____