

# Clayton Eye Center

Tech Review \_\_\_\_\_

Medical History

Doctor Review \_\_\_\_\_

Date: \_\_\_\_\_ Valid for One Year from Date

NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ M / F RACE \_\_\_\_\_

REFERRAL DOCTOR \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

Past Eye History: (Please list all surgery in the box on the right)

Family History:    Glaucoma        Macular Degeneration        Cataracts

Other \_\_\_\_\_

Social History:    Smoking        Alcohol        Blood Transfusion?

Does your vision limit any activity of daily living?        YES        NO

Occupation: \_\_\_\_\_

Females:        Are you PREGNANT or NURSING?        YES        NO

Do you currently have or have you had one of the following:

(Circle)

Y / N **Endocrine:**        (diabetes, thyroid, etc)

Y / N **Cardiovascular:**        (high BP, high cholesterol, racing pulse, etc)

Y / N        Other \_\_\_\_\_

Y / N **Respiratory:**        (congestion, wheezing, short of breath, asthma, emphysema, etc)

Y / N        Other \_\_\_\_\_

Y / N **Neurological:**        (headaches / migraines / MS / stroke / paralysis, seizures, etc)

Y / N **Psychiatric:**        (anxiety, depression, insomnia)

Y / N **Blood/Lymph:**        (anemia, bleeding, hepatitis, sickle cell, HIV+, AIDS, cholesterol, etc)

Other \_\_\_\_\_

Y / N **Muscles, Bones, Joints:**        (joint pain, stiffness, swelling, arthritis, cramps, etc.)

Y / N **Gastrointestinal:**        (ulcer, hernia, stomach upset, chronic diarrhea, etc.)

Y / N **Allergic/Immunologic:**        (lupus, sarcoid, sneezing, swelling, itching, redness, etc)

Y / N **Kidney, Bladder, Genital:**        (frequent or painful urination, yellow jaundice, etc)

Y / N **Skin**        (growths, rash, etc.)

Y / N **Ears, Nose, Throat:**        (hard of hearing, chronic sinus, cough, surgery, etc.)

Y / N **Cancer:**        What type? \_\_\_\_\_

Y / N        Are you currently receiving treatment? \_\_\_\_\_

Y / N **General Constitution:**        (fever, unusual weight loss/gain, unusually tired, etc)

Y / N **Other Medical History or Surgery:** \_\_\_\_\_

Y / N **Allergies** (Please list all allergies in the box on the right)

Are you currently interested in: **Glasses .Sunglasses Contact Lenses LASIK**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Turn over for updates within the same calendar year

**EYE SURGERY**

1

2

3

4

5

**EYE MEDICATIONS**

Prescribed or Over the Counter

1

2

3

4

5

**OTHER MEDICATIONS**

Prescribed or Over the Counter

1

2

3

4

5

6

**ALLERGIES**

**REVIEW/UPDATE WITHIN THE SAME CALENDAR YEAR**

DATE: \_\_\_\_\_ TECHNICIAN: \_\_\_\_\_

No Changes

Yes, Changes

Medications:

---

---

---

---

Health:

---

---

---

---

DATE: \_\_\_\_\_ TECHNICIAN: \_\_\_\_\_

No Changes

Yes, Changes

Medications:

---

---

---

---

Health:

---

---

---

---

DATE: \_\_\_\_\_ TECHNICIAN: \_\_\_\_\_

No Changes

Yes, Changes

Medications:

---

---

---

---

Health:

---

---

---

---