

Austin Eyecare

Medical Information Sheet

Patient Name _____ Date of Birth _____

Do you currently wear glasses? Yes No

Do you currently wear contacts? Yes No

Have you had any eye infections? Yes No

Have you had any eye injuries? Yes No

Approximate date of last eye exam _____

Rate your vision with your present correction (most commonly used): Good Fair Poor

Have you been diagnosed with:

Glaucoma Yes No

Cataracts Yes No

Allergies Yes No

Migraine headaches Yes No

Lazy eye Yes No

Do you experience:

Halos Yes No

Watery or itchy eyes Yes No

Dry eyes Yes No

Double vision Yes No

Flashes of light Yes No

Do you experience frequent headaches? Yes No If yes, how often? _____

Additional information: _____

How is your general health? _____

Have you experienced difficulties with any of the following systems or disorders?

Gastrointestinal Yes No

Ears/Nose/Throat Yes No

Cardiovascular Yes No

Respiratory Yes No

Diabetes Yes No

Skin disorders Yes No

Nervous Yes No

Musculoskeletal Yes No

Blood/Lymph Yes No

Thyroid Yes No

High/Low Blood Pressure Yes No

Other health problems: _____

Medical Information Sheet Continued

Have you had any surgeries: Yes No Type _____
Do you use cigarettes/tobacco? Yes No Alcohol? Yes No
Other Substances? Yes No
Current medications: _____

Allergic to Medications: _____

Family History

Please check yes or no if anyone in your family has been diagnosed with the following:

Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Macular degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Retinal detachment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lazy eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neurological disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other family history/eye conditions	_____	

Patient/Parent if minor signature _____ Date _____