The Vision Clinic Medical History and Demographic Information Worksheet

*Please completely fill out **ALL** sections of this information packet.*

Today's Date _____ Chart # _____

Name _____ Date of Birth _____ Social Security # _____

Address _____ City _____ State _____ Zip Code _____

Phone 1 _____ Phone 2 _____ Phone 3 _____

Email _____ Referred By _____

Employer/Occupation _____ Preferred Language _____

Medical Insurance _____ Member ID _____

Vision Insurance _____ Member ID _____

Primary Insured _____ Date of Birth _____ Social Security # _____

Current Medical Doctor _____ Most Recent Medical Exam Date _____

Previous Eye Doctor _____ Most Recent Eye Exam Date _____

Race
- ☐ African American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Caucasian/White
- ☐ European
- ☐ Filipino
- ☐ Hispanic
- ☐ Native Hawaiian/Pacific Islander

Ethnicity
- ☐ Hispanic/Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ None of the above

Communication Preference
- ☐ Call
- ☐ Email
- ☐ Mail
- ☐ Text

Sex
- ☐ Male
- ☐ Female

Do you wear glasses?
- ☐ Yes
- ☐ No

Do you wear contacts?
- ☐ Yes
- ☐ No

Ocular/Medical History	*Self*		*Family*	
	Yes	No	Yes	No
Glaucoma				
Cataracts				
Macular Degeneration				
Eye Injury				
Retinal Disease				
Loss of Vision/Blindness				
Eye Turn/Strabismus				
Lazy Eye/Amblyopia				
Eye Infection				
Dry Eye				
High Blood Pressure				
Diabetes				
Other Disease/Prematurity				

Patient Review of Health (current & previous)	*Self*	
	Yes	No
Constitution (Fever, Weight Gain/Loss)		
Cardio/Vascular (Diabetes, HBP, Stroke)		
Ear, Nose, Throat, Mouth (Allergies, Sinus)		
Respiratory (Asthma, Bronchitis, Emphysema)		
Gastrointestinal (Diarrhea, Constipation)		
Genitourinary (Genitals, Kidneys, Bladder)		
Musculoskeletal (Arthritis, Joint/Muscle Pain)		
Integumentary (Skin)		
Neurological (Headaches, Migraines, Seizures)		
Psychiatric (Mental/Emotional)		
Endocrine (Thyroid/Other Glands)		
Hematologic/Lymphatic (Anemia, Bleeding)		
Allergic/Immunologic (Allergy)		

Previous Surgeries/Hospitalizations (explain)

_____

_____

Medication Allergies _____

_____

Medications - Please list **ALL** current medications.
(prescriptions, over-the-counter, vitamins, supplements, contraceptives, etc.)

_____

Social History	Yes	No
Current Smoker?		
How many years have you been smoking?		
Previous Smoker?		
What year did you quit?		
Recreational Drug User?		
Do you drink alcohol?		
How often do you drink alcohol?		
Currently pregnant/nursing?		

Please continue ALL surgeries, hospitalizations, medication allergies, and medications on the back of this page. . .

Doctor's Signature _____