MEDICAL HISTORY

Name: ____ Birth Date: ________ Birth *State*: _______

Address: ______________________________ City: ________________ State: ____ Zip _______

Home Phone: ____________ Cell Phone: ____________ Email: ________________ SSN: _____-_____-_______

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Minor Gender: ❑ Male ❑ Female
Race: ❑ American Indian or Alaska Native ❑ Asian ❑ African American ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Other
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown Mother's Maiden Name: ______________________

Occupation: __________________________ Employer: _____________________ Work Phone: ____________

Business Address: _______________________ City: ________________ State: ____ Zip: _______

If Married, Spouse's Name: __________________________________ Employer: ___________________

If a Minor, Parent/Guardian's Names: ____

Nearest Relative (not at same address): ___________________________ Phone: ______________________

Address: _____________________________________ City: ________________ State: ____ Zip: _______

Person responsible for payment of account: _____________________________ Relationship to Patient: ________________

Address (if different): ______________________________ City: ________________ State: ____ Zip _______

SSN: _____-_____-_______ Home Phone (if different): __________ Medical Insurance Carrier/ID: ____________________

Where do you prefer we contact you? ❑ home ❑ work ❑ cell phone ❑ e-mail ❑ text message

Who may we thank for referring you to our office? _________________ Address: _______________________________

Has any member of your family been treated by our doctors? If so, list names: _______________________________________

Reason for making this appointment: ____

Last Eye Exam: ___________ Last Medical Exam: ___________ Name of Medical Doctor: ______________________

Are you allergic to any medications? Y / N If yes, please list: ____

Are you now using or have you ever used the medication Flomax? Y / N

On Page 2, list any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies).

Have you had: ❑ crossed/lazy eyes, ❑ drooping eyelid, ❑ glaucoma, ❑retinal disease, ❑ cataracts, ❑ eye infections, ❑ eye injury/surgery

Do you wear glasses? Y / N How old is your current pair of glasses? _______________________________________

Do you wear contact lenses? Y / N How old is your current pair of contact lenses? _____________________________

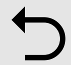
Type of contact lenses: ❑ Soft daily wear ❑ Disposables ❑ Extended wear ❑ Rigid ❑ Other _____ Are they comfortable? Y / N

I hereby authorize the release of any medical and/or other information necessary to process this claim. I also authorize my insurance benefits to be paid directly to Doctors Jury, Farrar or Green. I understand that I am financially responsible for any service including services not paid in full by my insurance company, and/or in the event that I do not have medical insurance.

____ ___________________

Signature: Patient / Parent / Guardian Date

***Please turn this form over and complete side two ***



MEDICAL HISTORY

JURY, FARRAR
& ASSOCIATES
EYECARE EXCELLENCE

FAMILY HISTORY: Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

Condition	No	Yes	?	Relationship to you:
Glaucoma	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Cataract	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Macular Degeneration	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Retinal Detachment/Disease	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Crossed Eyes	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Blindness	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Diabetes	❑ No	❑ Yes	❑ ?	Relationship to you: ______
High Blood Pressure	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Heart Disease	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Cancer	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Arthritis	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Kidney Disease	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Lupus	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Thyroid Disease	❑ No	❑ Yes	❑ ?	Relationship to you: ______
Other ______	❑ No	❑ Yes	❑ ?	Relationship to you: ______

REVIEW OF SYSTEMS: Do you currently, or have you ever had any problems in the following areas:

Please list medications you take for the following problems (including oral contraceptives, aspirin, over-the-counter medications and home remedies):

System	No	Yes	Medications Used
Eyes			
Loss of Vision	❑	❑	______
Blurred Vision	❑	❑	______
Distorted Vision/Halos	❑	❑	______
Loss of Side Vision	❑	❑	______
Double Vision	❑	❑	
Dryness	❑	❑	______
Mucous Discharge	❑	❑	______
Redness	❑	❑	
Sandy/Gritty Feeling	❑	❑	______
Itching	❑	❑	______
Burning	❑	❑	
Foreign Body Sensation	❑	❑	______
Glare / Light Sensitivity	❑	❑	______
Eye Pain or Soreness	❑	❑	______
Chronic Infection of Eye or Lid	❑	❑	
Sties or Chalazion	❑	❑	______
Flashes in Vision	❑	❑	______
Floaters in Vision	❑	❑	______
Tired Eyes	❑	❑	______
Constitutional			
Fever, Weight Loss/Gain	❑	❑	______
Integumentary (skin)	❑	❑	______
Neurological			
Headaches	❑	❑	______
Migraines	❑	❑	______
Seizures	❑	❑	______
Endocrine			
Thyroid / Other Glands	❑	❑	______
Ears, Nose, Mouth, Throat			
Allergies / Hay Fever	❑	❑	______
Sinus Congestion	❑	❑	______
Runny Nose	❑	❑	______
Post-Nasal Drip	❑	❑	______
Chronic Cough	❑	❑	______
Dry Throat / Mouth	❑	❑	______
Respiratory			
Asthma	❑	❑	______
Chronic Bronchitis	❑	❑	______
Emphysema	❑	❑	______

System	No	Yes
Vascular / Cardiovascular		
Diabetes	❑	❑
Heart Pain	❑	❑
High Blood Pressure	❑	❑
Vascular Disease	❑	❑
Gastrointestinal		
Diarrhea	❑	❑
Constipation	❑	❑
Genitourinary		
Genitals / Kidney / Bladder	❑	❑
Are you Pregnant or Nursing?	❑	❑
Bones / Joints / Muscles		
Rheumatoid Arthritis	❑	❑
Muscle Pain	❑	❑
Joint Pain	❑	❑
Lymphatic / Hematologic		
Anemia	❑	❑
Bleeding Problems	❑	❑
Allergic / Immunologic	❑	❑
Psychiatric	❑	❑

SOCIAL HISTORY: *(information is kept confidential)*

❑ I wish to discuss this section directly with the doctor.

Do you drive?	❑	❑
Visual difficulty when driving?	❑	❑
Please describe: ______		
Do you use tobacco products?	❑	❑
Type/Amount/How Long ______		
Do you drink alcohol?	❑	❑
Type/Amount/How Long ______		
Do you use illegal drugs?	❑	❑
Type/Amount/How Long ______		

Have you ever been exposed to or infected with:

❑ Gonorrhea ❑ Hepatitis ❑ HIV / AIDS
❑ Syphilis ❑ Chlamydia

Other Notes: ______