MEDICAL HISTORY

List Current Medications (including eye medications):

_____

_____

_____

Last Eye Exam_____

Medical Dr. Name_____

Medical Dr. Phone_____

Last Medical Exam_____

Any known eye disease?_____

Eye injury or surgery?_____

Any allergies?_____

Is there a Family History of (check all that apply):

		Relationship To You
☐	Blindness	_____
☐	Cataracts	_____
☐	Crossed Eyes	_____
☐	Glaucoma	_____
☐	Macular Degeneration	_____
☐	Retinal Detachment	_____
☐	Arthritis	_____
☐	Cancer	_____
☐	Diabetes	_____
☐	Heart Disease	_____
☐	High Blood Pressure	_____
☐	Kidney Disease	_____
☐	Lupus	_____
☐	Thyroid Disease	_____
☐	Other	_____

Do you currently have, or have you ever had any problems in the following area?

	No	**Yes**
Constitutional		
Fever/Weight Loss/Gain	☐	☐
Cardiovascular/Vascular		
Diabetes	☐	☐
High Blood Pressure	☐	☐
Ears, Nose, Mouth, Throat		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Respiratory		
Asthma	☐	☐
Gastrointestinal		
Diarrhea	☐	☐
Constipation	☐	☐
Genitourinary		
Genitals/Kidney/Bladder	☐	☐
Musculoskeletal		
Arthritis	☐	☐
Integumentary		
Skin	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Psychiatric	☐	☐
Endocrine		
Thyroid/Other Glands	☐	☐
Hematologic/Lymphatic		
Anemia	☐	☐
Bleeding Problem	☐	☐
Allergic/Immunologic	☐	☐
Eyes		
Loss of Vision	☐	☐
Distorted Vision	☐	☐
Loss of Side Vision	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Chronic Infection of Eye/Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐

Do you use eye drops?
☐ No ☐ Yes – what type?_____

Do your eyes feel dry, painful, or sore?
☐ Never ☐ Sometimes ☐ Often ☐ Always

Do your experience episodes or periods of blurred vision?
☐ Never ☐ Sometimes ☐ Often ☐ Always

How often do your eyes feel tired?
☐ Never ☐ Sometimes ☐ Often ☐ Always

Do you have problems with your eyes when you are working on a computer, watching TV or reading?
☐ Never ☐ Sometimes ☐ Often ☐ Always

Payment is expected at time services are provided. We accept cash, check, MasterCard, Visa and Discover. Payment in full is required on all materials ordered.

I authorize payment to Mission Optometry and/or Robert J. Joyce, O.D., APC for all benefits now due or becoming due under my Medicare or group insurance policy for the services that have been rendered.

I authorize the release of my (or my child's) medical records as deemed necessary by the staff of Mission Optometry to a Medical Provider or on the request from a Medical Provider. I hereby acknowledge receipt of a copy of my Patient Health Information Privacy Policy.

_____

patient/parent or guardian signature)

_____

(date)