PATIENT EVALUATION AND MEDICAL HISTORY

Patient Name: ______________________ Date: ________

Age: ________ Sex: M F Marital Status: Single Married Divorced Widowed

Date of Birth: ________ Ethnicity: ________

Occupation: ________

Hobbies: ________

Who referred you to Dr. Mullins? ________

Current Medical Doctor: ________

What are your reasons for this visit? ________

If this is a medical eye problem (red eye, injury, etc.) please list details as to when or how this began or occurred and any treatment rendered thus far:

PATIENT OCULAR HISTORY

When was your last eye exam? ________ Doctor: ________

Have you ever been prescribed corrective lenses? ☐ Yes ☐ No

How long ago? ________

Do you currently wear: ☐ Glasses ☐ Contacts ☐ Both ☐ None

How often do you wear them? ☐ Full Time ☐ Part Time

Please list any special vision tasks that you have at work or at home:

PAST EYE HISTORY (where appropriate, list dates and which eye involved)

Known Eye Diseases: ________

Previous Eye Operations: ________

Previous Eye Injuries: ________

PAST MEDICAL HISTORY

Medical Conditions

Diabetes ☐ Yes ☐ No How Long? ________

Heart Disease ☐ Yes ☐ No How Long? ________

High Blood Pressure ☐ Yes ☐ No How Long? ________

Collagen Vascular Disease (Lupus, Arthritis, Crohn’s, etc.): ________

Other (please list): ________

Allergies to Medicines: ________

Eye Medications: ________

FAMILY HISTORY (blood relatives only)

Retinal Detachment ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No

Macular Degenerations ☐ Yes ☐ No

Blindness ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No

SOCIAL HISTORY

Smoking History ☐ Yes ☐ No How Long? ________

Packs Per Day? ________

Alcohol/Drug History ☐ Yes ☐ No How Long? ________

How Much? ________

PLEASE COMPLETE BACK SIDE OF THIS PAGE

Do you currently, or have you previously, had any problems in the following areas?

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (SKIN)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye/Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
ENDOCRINE			
Thyroid or Other Glands	☐	☐	☐
IMMUNOLOGIC	☐	☐	☐

SYSTEM	NO	YES	?
EAR/NOSE/MOUTH/THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
PHSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain below:

KNOWN MEDICATION ALLERGIES:

PRIMARY CARE PHYSICIAN:

Please list any medications (including over the counter, vitamins, etc.) that you are currently taking:

Name of Drug	Dosage

FOR OFFICE USE ONLY

Tech Signature	Review/Date
Doctor Signature	Review/Date
Date Reviewed/Updated	Tech Signature
Date Reviewed/Updated	Tech Signature
Date Reviewed/Updated	Tech Signature
Date Reviewed/Updated	Tech Signature
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Date Reviewed/Updated	Tech Signature
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