Medical History Form

New York Vision Associates

Date ____/____/_____

Patient Name: Last: _____ First: _____

Address: _____ **Phone:** (_____) _____

City, State, Zip: _____, _____ _____ **Cell:** (_____) _____

E-Mail: _____ **Text Messaging:** Yes No

Birthdate: _____/_____/_____ **Gender**: M F **Social Security #** _____-_____-_____

Ethnicity/Race: _____ **Last Eye Exam** ____/____/_____

Employer: _____ **Occupation:** _____

General Health History (Please circle **any** and ***all*** known problems): *Check here if None:* ☐

Seasonal Allergies	Hypertension	Heart Disease	High Cholesterol	Thyroid Disease
Digestive Problems	Urinary Disorder	Autoimmune Disorder	Skin Disorder	Blood Disorder
Arthritis	Neurologic Disorder	Psychiatric Disorder	Asthma	

Diabetes (Please include date of diagnosis): _____

Other health issues (please specify): _____

Are you pregnant and/or nursing Yes No

Medication History (Please list ***any*** and ***all*** medications currently taken): *Check here if None:* ☐

_____

_____

Allergies to Medications: _____ *Check here if None:* ☐

Personal Eye History (Please circle **any** and ***all*** known eye problems): *Check here if None:* ☐

Glaucoma	Cataracts	Keratoconus	Lazy Eye	Macular Degeneration
Eye Injury	Eye Infection	Eye Surgery	Floaters	Retinal Detachment
Allergies	Dry Eye	Color Deficiency	Pterygium	Diabetic Retinopathy

Other (Please specify): _____

Do you wear glasses?: Yes No For: Distance Near Computer if yes, from how long ago? _____

Do you wear contact lenses?: Yes No Type/Brand: _____

Are you interested in LASIK?: Yes No Done in past (Please list year): _____

Family Health History (Please list ***any*** and ***all*** known problems) *Check here if None:* ☐

Hypertension	Relationship: _____	Glaucoma	Relationship: _____
Diabetes	Relationship: _____	Cataracts	Relationship: _____
Thyroid Disease	Relationship: _____	Macular Degeneration	Relationship: _____
Cancer	Relationship: _____	Keratoconus	Relationship: _____

Other (Please list any other known conditions not listed above): _____

Emergency Contact: _____ Relationship:_____ Phone: (_____) _____

Primary Care Physician: _____ Phone: (_____) _____

Vision Insurance: _____ **Health Insurance:** _____

Please state the main reason for your visit today: _____

_____

All information disclosed on this form is strictly confidential and conforms to HIPAA regulations.