Personal Medical History

Constitutional
☐Fever
☐Weight loss/gain
☐Fatigue
☐Trauma
☐Cancer
☐Developmental Disabilities

Neurologic
☐MS
☐Epilepsy
☐Cerebral Palsy
☐Tumor
☐Migraine

Cardiovascular
☐High Blood Pressure
☐Stroke/CVA
☐Heart Disease
☐Vascular Disease
☐Congestive Heart Failure

Respiratory
☐Asthma
☐Bronchitis
☐Emphysema
☐Chronic Obstruction
☐Sleep Apnea

Ear/Nose/Throat
☐Hearing Loss
☐Sinusitis
☐Dry Mouth

Psychiatric
☐Depression
☐ADD/ADHA
☐Anxiety
☐Bipolar Disorder

Genitourinary
☐Kidney Disease
☐Prostate Disease
☐STD

Integumentary
☐Eczema
☐Rosacea
☐Psoriasis
☐Herpes Zoster/Shingles

Endocrine
☐Type 2 Diabetes Mellitus
☐Type 1 Diabetes Mellitus
☐Herpes Simplex
☐Thyroid Dysfunction
☐Hormonal Dysfunction

Gastrointestinal
☐Chrohn's
☐Colitis
☐Ulcer
☐Acid Reflux
☐Celiac Disease

Musculoskeletal
☐Osteoarthritis
☐Arthritis
☐Fibromyalgia
☐Muscular Dystrophy
☐Ankylosing Spondylitis
☐Osteoporosis
☐Gout

Hematologic/Lymphatic
☐Anemia
☐Ulcer
☐High Cholesterol

Autoimmume
☐Rheumtaoid Arthritis
☐Sjogren's
☐Lupus

Ocular/Eye History

☐Glaucoma ☐Cataract ☐Surgery ☐Patching ☐Inflammatory Disorder ☐Nystagmus
☐Strabismus ☐Amblyopia ☐Keratoconus ☐Dry Eye ☐Injury_____
☐Retinal Degeneration/Hole/Detachment ☐Age-Related Macular Degeneration ☐Other: _____

I wear: ☐Glasses ☐Contact Lenses
Contact Lens Brand: _____RX if known:_____

How long do you wear your contacts before you throw them away? _____
Do you sleep in your contacts? ☐Yes ☐No How many nights consecutively:_____
Contact Lens Solution: ☐Opti-Free (green bottle) ☐BioTrue (clear bottle) ☐Clear Care (bubbles)
☐Renu (blue bottle) ☐Generic---Meijer, Target, Equate ☐Other
Eye Drops: _____

Family History

Medical **Relation M/F/B/S /GM/GF**
☐High Blood Pressure_____
☐Diabetes_____
☐Cancer_____
☐Thyroid_____
☐Other: _____

Ocular
☐Glaucoma_____
☐Cataract_____
☐Surgery_____
☐Patching_____
☐Strabismus_____
☐Amblyopia_____

☐Age-Related Macular Degeneration
☐Inflammatory Disorder
☐Retinal Hole/Detachment
☐Keratoconus
☐Dry Eye
☐Other: _____

Welcome to Norton Eye Care

Patient Information

Salutation: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. Date: _____/_____/_____

Name: _____ Nickname: _____

Suffix: ☐Jr. ☐Sr. ☐II ☐III Credentials: ☐MD ☐OD ☐DO ☐DDS ☐PHD

Address: _____

Apt #: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____ Preferred Communication: ☐Phone ☐Email

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Gender: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Other

Guardian: _____ Relationship: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

How did you hear about us?

☐Drive by/Signage ☐Advertisement ☐Facebook/Twitter/Instagram ☐Google ☐Yelp
☐Insurance ☐CareCredit ☐Doctor Referral: _____
☐Friend or Family: _____

Primary Care Physician: _____

Previous Eye Doctor: _____ Last Eye Exam: _____/_____/_____

Employer: _____ Occupation: _____
Sports/Hobbies: _____

Drink: ☐Yes ☐No Smoke: ☐Yes ☐No

Major Injuries/Surgeries: _____

Medications: _____

Allergies: ☐Drug: _____ Blood Pressure: ____/____
☐Environmental _____
☐Latex