Milam's
COMMUNITY EYE CARE
770 483-4831

NAME: ______________________________

Date of Birth: ______________________________

Todays Date: ______________________________

EYE HEALTH HISTORY

Date of last eye exam ______________

Name of last eye doctor ______________

Do you wear glasses? ☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No

Type ___________ Brand ___________

Hours/Day ___________

Describe any problems you have with your contacts: ____________________

____

____

____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition			Condition		
Glaucoma *(If yes, please list drops used in medication section of Exam form)*	☐ Yes	☐ No	Dry Eyes	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Temporary Loss of Vision	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No	Eye Pain or Soreness	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No	Double Vision	☐ Yes	☐ No
Eye Injuries	☐ Yes	☐ No	Excessive Tearing	☐ Yes	☐ No
Retinal Disease	☐ Yes	☐ No	Itchy Eyes	☐ Yes	☐ No
Retinal Detachment	☐ Yes	☐ No	Burning or Red Eyes	☐ Yes	☐ No
Color Blindness	☐ Yes	☐ No	Flashes	☐ Yes	☐ No
Blindness (Complete Vision Loss)	☐ Yes	☐ No	Floaters	☐ Yes	☐ No
Strabismus (Lazy Eye / Crossed Eyes)	☐ Yes	☐ No	Glare Problems	☐ Yes	☐ No
Amblyopia (Uncorrectable Blurry Vision)	☐ Yes	☐ No	Light Sensitivity	☐ Yes	☐ No
Refractive (Correctable Blurry Vision) If yes, blurry distance or near vision or both___________	☐ Yes	☐ No			

Other eye problems (please list):___________

____

HEALTH HISTORY

Primary Care Physician's Name ______________________________

Specialty Physician's Name(s) ______________________________

Last medical exam ______________________________ with Dr. ______________________________

(PH) Have you ever had any surgery, major injuries and/or been hospitalized? ☐ Yes ☐ No

If yes, please explain: ______________________________

Do you have any Drug Allergies? ☐ Yes ☐ No

If yes, please list: ______________________________

REVIEW OF SYSTEMS

Please "X" the appropriate column and Circle conditions that apply.

☐ Yes ☐ No CONSTITUTIONAL, developmental disability, cancer, fever/chills, recent weight loss or gain, fatigue

☐ Yes ☐ No CARDIOVASCULAR HEART, high blood pressure, heart disease, vascular disease, stroke, irregular heartbeat

☐ Yes ☐ No ENDOCRINE, Insulin dependent diabetes, non insulin dependent diabetes, thyroid problems, hormonal problems

☐ Yes ☐ No NEUROLOGICAL, headaches, multiple sclerosis, cerebral palsy, tumor, seizures, numbness or tingling in extremities

☐ Yes ☐ No PSYCHIATRIC, dementia, anxiety, memory loss, difficulty concentrating, insomnia

☐ Yes ☐ No EARS/NOSE/MOUTH/THROAT, hearing loss, sinus problems, dry mouth, mouth sores

☐ Yes ☐ No ALLERGIC/IMMUNOLOGIC, environmental allergies, rheumatoid arthritis, lupus, HIV/AIDS

☐ Yes ☐ No RESPIRATORY, Asthma, bronchitis, emphysema, COPD, cough

☐ Yes ☐ No MUSCULOSKELETAL, Arthritis, Fibromyalgia, muscular dystrophy, ankylosing spondylitis, back or neck pain

☐ Yes ☐ No GASTROINTESTINAL, heartburn, crohn's disease, ulcer, colitis

☐ Yes ☐ No GENITOURINARY, kidney problems, prostate problems, frequent urination, sexually transmitted disease

☐ Yes ☐ No HEMATOLOGIC/LYMPHATIC, high cholesterol, anemia, blood loss, sickle cell, leukemia

☐ Yes ☐ No INTEGUMENTARY/SKIN, rosacea, psoriasis, skin cancer, rash

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SOCIAL HISTORY

Are you pregnant or nursing? ☐ Yes ☐ No ☐ N/A

Do you use tobacco products? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Occupation______________________________

Do you use a computer at work? ☐ Yes ☐ No

if yes, how many hours daily? ____________

Please list Sports / Hobbies that you participate in regularly:

____

____

____

FAMILY HISTORY

Please Identify if any blood relatives has had any of the following problems:
(If yes, please explain relationship to you)

	YES	NO	RELATIONSHIP
Glaucoma	☐	☐	____________
Cataracts	☐	☐	____________
Macular Degeneration	☐	☐	____________
Retinal Disease	☐	☐	____________
Retinal Detachment	☐	☐	____________
Blindness (Complete Vision Loss)	☐	☐	____________
Lazy Eye	☐	☐	____________
Diabetes	☐	☐	____________
Heart Disease	☐	☐	____________
High Blood Pressure	☐	☐	____________
Kidney Disease	☐	☐	____________
Thyroid Disease	☐	☐	____________
Cancer	☐	☐	____________