# MEKAS FAMILY EYECARE

## PATIENT HISTORY FORM

Patient's name: ______________________________ Today's Date: ________________ Age: ________
Address: ___________________________________ City: _________ State: ________ Zip code: ________
Home Phone: _____________ Work Phone: ___________ Cell: _____________ Birth Date: ___/___/_____
Name of your insurance: ______________________ SS # of primary insured: _______/_____/_______
Employer of primary insured: __________________ Occupation of patient: _________________________
Date of last eye exam: ____________ Reason for today's eye exam _________________________________
Do you wear contact lenses? ______ If yes, how long have you worn contact lenses? ________________
Please list all medications you take: ______________________________________________________
What allergies do you have if any? _______________________________________________________
List all major injuries, surgeries, medical conditions and or hospitalization you have or have had: ______________________________________________
When was your last medical Exam? _____________ When was your last Dental Exam? ______________

**Social history:** (Circle yes or no when necessary)

Do you drive? Yes / No. If yes, do you have vision difficulty when driving? Yes / No
Do you drink alcohol, smoke or use illegal drugs? Yes / No. If YES, specify the type(s), amount and duration: ______________________________________________
Do you use computer? Yes / No. If yes, how many hours daily? ______
Have you ever been exposed to or infected with Gonorrhea, Syphilis or HIV? Yes / No. If yes, specify the disease(s): ______________________________________________

**Review of systems:** (Circle yes or no)

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

| | |
|---|---|
| Constitutional, (e.g. fever, weight loss or gain): | Yes / No |
| Musculoskeletal: | Yes / No |
| Eyes: | Yes / No |
| Integumentary (skin): | Yes / No |
| Ear, Nose, Mouth, and Throat: | Yes / No |
| Neurological (e.g. migraine, seizures): | Yes / No |
| Cardiovascular (e.g. diabetes, high blood pressure, heart pain) | Yes / No |
| Psychiatric: | Yes / No |
| Respiratory (e.g. asthma): | Yes / No |
| Endocrine (e.g. thyroid problem): | Yes / No |
| Gastrointestinal (e.g. diarrhea, constipation): | Yes / No |
| Hematologic/Lymphatic (e.g. anemia, bleeding problems): | Yes / No |
| Genitourinary (e.g. genitals, kidney problems): | Yes / No |
| Allergic/Immunologic: | Yes / No |

If you answered YES to any of the above or have a condition not listed, please explain and list medications ______________________________________________

**Family History:**

Please circle YES if any of your family members has or had any of the following conditions, otherwise circle NO. Also state your relationship with the member.

| | | |
|---|---|---|
| Blindness: | Yes / No | Relationship: ______________ |
| Cataract: | Yes / No | Relationship: ______________ |
| Crossed Eyes: | Yes / No | Relationship: ______________ |
| Glaucoma: | Yes / No | Relationship: ______________ |
| Macular degeneration: | Yes / No | Relationship: ______________ |
| Diabetes: | Yes / No | Relationship: ______________ |
| High blood pressure: | Yes / No | Relationship: ______________ |
| Arthritis: | Yes / No | Relationship: ______________ |
| Other conditions not listed __________ | | Relationship: ______________ |

Patient's/Patient's legal representative signature: __________________________ Date: ______________
Reviewed by Doctor Nwokedi/ _________ Dr's Signature ______________________ Date: ______________