ID#

Family Eye Care
Medical History Questionnaire

Name:____Date of Birth:__________

Date:_________________________________

The email address is very important! It will be our way of communicating with you regarding medical information, medical health record, etc.
Email Address:____Cell Phone: _________________________

How would you like to be notified of appointments?___Home___Cell___Work___Email____Postal
Is texting your cell phone for appointment reminders okay? ___Yes ____No

Preferred Pharmacy: _________________________________

Number of alcoholic drinks per day _____
Number of cigarettes per day _________

Height: ________ **Weight:** ________

Primary Care Physician:____ Are you pregnant? Yes__No__

If diabetic, what was your last blood sugar and time_____ A1C(3 month average)______

Reason for visit:____

____

Please check all the following conditions that you experience:

☐Headaches	☐Glare/Light Sensitivity	☐Tired Eyes
☐Burning	☐Dryness	☐Eye Pain or Soreness
☐Foreign Body Sensation	☐Infection of Eye or Lid	☐Itching
☐Mucous / Discharge	☐Drooping Eyelid	☐Redness
☐Sandy or Gritty Feeling	☐Lazy Eye	☐Crossed Eye
☐Blurred Vision Distance	☐Blurred Vision Near	☐Distorted Vision
☐Double Vision	☐Floaters or Spots	☐Fluctuating Vision
☐Loss of Vision	☐Excessive Tearing	☐Loss of Side Vision
☐Halos / Starbursts around lights	☐Flashes of Light	☐Excessive Eye Rubbing

Students:

☐Trouble following a line of print	☐Trouble focusing on electronic device	☐Trouble focusing near to far

If you marked any of the above or have a condition not listed, please explain below.

____

____

Please list any eyedrops/eye ointments, dosages, frequency and why you take them:

____

____

Do you have any drug allergies? Yes____No___ If yes, please list them:

____

Signature ____ **Date**____________________

Family Eye Care
100 N Main Street
LaBelle FL 33935
(863) 675-0761

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the optometrist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your optometrist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Parrish and/or Dr. Youmans or their assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

______________________________ ______________

Patient (or person authorized to sign for patient) Lifetime Signature Date

______________________________ ______________

Witness Date