BESSEMER
FAMILY EYE CARE

Information and Medical History Form

Patient Name: _____ Birthdate: _____

Have you had any changes in your home address since your last visit?			Yes	No
Have you had any changes in your phone number since your last visit?			Yes	No
Have you had any changes in your insurance information?			Yes	No
Are you seeing well with your current glasses?	Yes	No	N/A	
Do you want to update your current glasses?	Yes	No		
Do you see well with your current contacts?	Yes	No	N/A	
*If yes, is your comfort good?	Yes	No		
*Are your backup glasses up to date?	Yes	No		
Are you interested in trying contacts?	Yes	No		
Are you interested in prescription sunglasses?	Yes	No		
Are you interested in thinner, lighter lenses?	Yes	No		
Do you have problems with glare?	Yes	No		
Are you interested in LASIK?	Yes	No		

If yes, please list below:
Address: _____
_____
Phone: _____

Medical Insurance:
Carrier: _____
Subscriber: _____
Policy #: _____

Vision Insurance:
Carrier: _____
Subscriber: _____
Policy #: _____

What medications are you currently taking? (Prescription and over-the-counter): _____
_____
_____
_____

Are you pregnant? Yes No

Do you have allergies to any medications?	Yes	No	If yes, please list: _____
Any major illnesses or injuries since your last visit?	Yes	No	If yes, please list: _____
Any surgeries since your last visit?	Yes	No	If yes, please list: _____

Do you currently have any problems in the following areas? **If yes, please provide details in the space below.**

Eyes (blur, glare, redness, pain)	Yes	No
General/Constitutional (fever, fatigue, etc)	Yes	No
Ears, Nose, Throat (stuffy nose, cough, dry mouth, etc)	Yes	No
Cardiovascular (hypertension, racing pulse, etc)	Yes	No
Respiratory (congestion, wheezing, etc)	Yes	No
Gastrointestinal (ulcers, diarrhea, etc)	Yes	No
Genitourinary (bladder infection, kidney disease, etc)	Yes	No
Musculoskeletal (arthritis, osteoporosis, etc)	Yes	No
Integumentary (rash, hives, acne, etc)	Yes	No
Neurological (headache, numbness, etc)	Yes	No
Psychiatric (anxiety, depression, insomnia, etc)	Yes	No
Endocrine (diabetes, thyroid disease, etc)	Yes	No
Blood/Lymph (high cholesterol, anemia, HiV, etc)	Yes	No
Allergic/Immunologic (seasonal allergies, etc)	Yes	No

Family History: Any changes to family medical history (parents, grandparents, siblings) since your last visit? Yes No
If yes, please describe: _____

Social History: Changes in employment?	Yes	No	If yes, _____	
Changes in marital status?	Yes	No	If yes, _____	
Changes in driving habits?	Yes	No	If yes, _____	

Do you drink alcohol? Yes No If yes, occasional? 1/day? 2-3/day? 4+/day?
Do you use tobacco? Yes No If yes, occasional? Type: _____ ½ pack/day? 1 pack/day? More?
Have you been exposed to or infected with: HIV? Hepatitis? Syphilis? Gonorrhea?

Doctor's Signature: _____ Date: _____