Blue Hills Eye Associates

Dr. Daniel Thurm
Dr. Jamie DeLugan

MEDICAL HISTORY FORM

PLEASE PRINT

Patient name: ____Today's date: __________________

Briefly describe the reason for today's visit: ____

____

Occupation: ____

Do you wear eyeglasses ? Yes / No If yes: Distance only, Near only, Full time, Bifocals, Single vision

Do you wear contact lenses ? Yes / No If yes: type: ____

Current care system: __________________________________

If you do not wear contact lenses, would you like to discuss your contact lens options during your eye examination ? Yes / No

Do you work on a computer ? Yes / No If yes, how many hours per day do you spend on it ? _________________

Do you smoke ? Yes / No

Do you drink alcohol ? Yes / No If yes, what is the average number of drinks per week ? _________________

When was your last eye examination ? __________________ Your last physical examination ? __________________

Please give the name, address, and telephone number of your Primary Care Physician:

____

____

____ Telephone : (______) _______ - ______________

Please list all **allergies** you have including those to medications: ____

____

Please list all **oral medications** you are taking:____

____

Please list all **eye medications** you are taking:____

____

PLEASE TURN OVER

Do you or any of your family members have any of the following conditions:

	Yourself:		Family:		Relationship:
Gastrointestinal disease	Yes	No	Yes	No	________________
High Blood Pressure	Yes	No	Yes	No	________________
Heart Disease	Yes	No	Yes	No	________________
Diabetes Mellitus	Yes	No	Yes	No	________________
Asthma	Yes	No	Yes	No	________________
Arthritis	Yes	No	Yes	No	________________
Cancer	Yes	No	Yes	No	________________
Migraine Headaches	Yes	No	Yes	No	________________
Liver Disease	Yes	No	Yes	No	________________
Seizure Disorder	Yes	No	Yes	No	________________
Bleeding Disorder	Yes	No	Yes	No	________________
Glaucoma	Yes	No	Yes	No	________________
Cataract	Yes	No	Yes	No	________________
Retinal Detachment	Yes	No	Yes	No	________________
Strabismus (eye turn)	Yes	No	Yes	No	________________
Amblyopia (lazy eye)	Yes	No	Yes	No	________________
Macular Degeneration	Yes	No	Yes	No	________________
Retinal Disease	Yes	No	Yes	No	________________
Ocular Tumor / Cancer	Yes	No	Yes	No	________________

Have you ever had surgery on either of your eyes ? Yes / No Serious injury to either eye ? Yes / No

If yes, please explain: ____

____

Is there anything else you feel we should know about you that would help us to better care for you?

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