Dubin Optometric Clinic Patient:									
<b>Medical History Ques</b>	tionna	ire	DOB:	Date:					
Guardian (If Applicable):				Patient's Occupation:					
Primary Medical Insurance:				Last Eye Exam:///					
Secondary Medical Insurance:		Last Medical Exam:							
Name of Primary Care Physician:		Dr's. Phone:							
Medical History									
Do you have any allergies to medica	tions:	I no 🗆	yes If yes,	which one:					
List any medications you take (inclu	ding oral c	contraceptiv	es, aspirin, ov	er the counter medications and home remedies)					
List all major injuries, surgeries and	or hospita	lizations yc	ou have had:						
List any of the following that you had isease, cataracts, eye infections, eye				oping eyelid, prominent eyes, glaucoma, retinal					
Are you pregnant and / or nursing?	no f	<b>J</b> yes							
Do you wear glasses?	□ no f	J yes I	f yes, how old	are your present pair(s) of glasses?					
Do you wear contact lenses?	no f	J yes I	f yes, how old	is your present pair of lenses?					
Type of contact lenses: □gas perm	□soft	Dextend we	ear 🗆 other	Are they comfortable? □ no □ yes					
Family History									
Please note any family history (pare	nts grandr	arents sibl	ings children	living or deceased) for the following:					
DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU					
Glaucoma									
Macular Degeneration			О						
Retinal Detachment / Disease									
Diabetes									
Heart Disease									
High Blood Pressure									
Other		_	_						

<sup>\*</sup> Please turn this form over and complete side two \*

Do you drive? □ no □ ve	s If v	es. do vou	have visu	al difficulty when driving? □ no □	ves		
If yes, please describe: _	-	-		•	<i>y</i>		
				often?   1-10 hr/wk   10-20 hr/wk	wk 🗖	more	
Do you experience: □h	eadach	es 🗆 glare	□trouble	with data entry  other concerns?			
Please list your sports / hobbies	s:						
<b>Review of Systems</b>							
Do you currently have any prol	blems in	the follow	ving areas				
	NO	YES	?		NO	YES	?
ALLERGIC / IMMUNE				NEUROLOGICAL			
CARDIOVASCULAR				Headaches			
Diabetes				Migranes			
High Blood Pressure				Seizures			
Heart/Vascular Disease				PSYCHIATRIC			
CONSITITUTIONAL				Psychiatric			
Fever, Weight Loss/Gain				EYES			
ENDOCRINE				Blurred Vision			
Thyroid / Other Glands				Double Vision			
HEAD (Ear, Nose, Throat)				Dryness			
Chronic Cough				Sandy or Gritty Feeling			
Chronic Sinus Congestion				Itching			
Dry Throat / Mouth				Burning			
HEMATOLOGIC				Foreign Body Sensation			
Anemia				Excess Tearing / Watering			
Bleeding Problems				Glare/Light Sensitivity			
INTEGUMENTARY (Skin)				Eye Pain or Soreness			
MUSCUOLOSCKELETAL				Flashes of Light			
Rheumatoid Arthritis				Floaters in Vision			
If you answered YES or have a	conditi	on not liste	ed, please	explain:			
Authorization							