NEWCASTLE VISION CLINIC
MEDICAL HISTORY FORM

Patient Information

Date: ____________________

Name: ____

Date of Birth: ____

What is the main purpose of this visit?

____

____

Name of Family Physician ____________________________

Location ____

Do you currently see any other eye specialist? ☐ Yes ☐ No

Name of doctor _____________________________________

Date of Last Eye Exam ______________________________

Location ____

Do you currently wear contact lenses? ☐ Yes ☐ No

Brand used ____

Solution used _______________________________________

Patient Eye History

Are you currently experiencing, been diagnosed or treated for any of the following?

☐ Cataracts	☐ Corneal Abrasions
☐ Eye turn/Lazy Eye	☐ Double Vision
☐ Eye Infections	☐ Eye Injury
☐ Flash of light	☐ Floaters/Spots
☐ Glaucoma	☐ Grittiness/Watery eyes
☐ Headaches	☐ Iritis/Uveitis
☐ Itchiness	☐ Trouble Seeing at Night
☐ Macular Degeneration	☐ Dry Eyes
☐ Retinal Detachment	☐ Sunlight Sensitivity

☐ Other eye disorders_________________________________

Is there a **Family Medical History** of any of the following:

	Yes	Relationship (parent, sibling, etc)
Blindness	☐	____________________
Cataracts	☐	____________________
Corneal Problems	☐	____________________
Retinal Problems	☐	____________________
Glaucoma	☐	____________________
Macular Degeneration	☐	____________________
Lazy Eye	☐	____________________
Diabetes	☐	____________________
Heart Disease	☐	____________________

Patient Medical History

CURRENT MEDICATIONS (Rx or Over the Counter) (List medications including eye drops, vitamins, & birth control pills)

____

____

ALLERGIES TO MEDICATIONS (please list names)?

____

Have you had any surgeries (please list type)? ____

Do you use cigarettes/tobacco, alcohol, or other substances? ☐ Yes ☐ No

Please mark if you have ever been diagnosed or treated for the following health problems

	Yes	Please Explain		Yes	Please Explain
Arthritis	☐	____________________	Integumentary (Skin)	☐	____________________
Blood/Lymph	☐	____________________	Thyroid	☐	____________________
Cancer	☐	Type:________________	Cholesterol	☐	____________________
Diabetes	☐	Type:________________	Digestive	☐	____________________
Ears/Nose/Throat	☐	____________________	Endocrine	☐	____________________
Kidney	☐	____________________	Cardiovascular	☐	____________________
Muscle/Bone	☐	____________________	Genitourinary	☐	____________________
High Blood Pressure	☐	____________________	Psychological	☐	____________________
Eczema/Rashes	☐	____________________	Respiratory	☐	____________________
Fatigue	☐	____________________	Neurological	☐	____________________
Sinus	☐	____________________	Allergies	☐	____________________
Unusual weight loss/gain	☐	____________________	Other	☐	____________________