Newberg Vision Clinic
Patient Medical History Form

(Some Insurance companies require answers to the following questions)

Please complete this form as accurately and completely as possible. Please print. Thank you.	
Today's Date	
Patient's Name (Last, First, MI)	
Patient's Date of Birth, Age	
When was your last eye exam? When was your last physical exam?	Eye Exam: _____ Physical Exam: _____ Physician: Physician:
Do you wear glasses?	Glasses (Please circle one): Yes No
Do you wear contacts?	Contacts (Please circle one): Yes No Type:_____
Primary reason for visit today	Routine Exam__ Other__ Cataract__ Glaucoma__ Diabetes__

Please list all current medications, including eye drops and non-prescription medications, in the space below.

Please list all allergies to medications or foods, and seasonal allergies, in the space below.

Do you experience any of the following? Headaches_____ Double Vision_____ Dry eyes _____Eyestrain_____

Please list all dates and type of surgery, including eye surgery, in the space below.

Please indicate if you (the patient) or a family member (parent, grandparent, brother, sister) ever had the following conditions.	Patient		Family member	
	Yes	No	Yes	No
01. Amblyopia, crossed or lazy eye?				
02. Cataracts?				
03. Eye infection?				
04. Eye injury?				
05. Glaucoma?				
06. Macular degeneration?				
07. Cardiovascular problems (high blood pressure, high cholesterol, heart disease, arrhythmia, cancer, etc.)?				
08. Endocrine problems (diabetes, high/low thyroid, cancer, etc.)?				
09. Neurological problems (stroke, numbness, weakness, headaches, paralysis, seizures, cancer, etc.)?				
10. Ear, nose, mouth/throat problems (hearing loss, sinus problems, sore throat, cancer, etc.)?				
11. Gastrointestinal/liver problems (heartburn, abdominal pain, cirrhosis, hepatitis, cancer, etc.)?				
12. Respiratory problems (wheezing, cough, asthma, tuberculosis, bronchitis, cancer, etc.)?				
13. Other conditions not mentioned above?				
14. Do you currently smoke, or have you ever smoked?				
15. Are you currently pregnant?				
16. Are you currently a nursing mother?				

Signature of Patient or Legal Guardian _____