Print Form

EYE DESIGNS
OPTOMETRY
Thomas H. Murphy, O.D.

Medical History Form

Patient Information

Patient First Name | Middle Initial | Last Name | Ms.
Street Address | Patient Date of Birth | Phone Numbers
City | Name of Primary Care Doctor | Home:
State | Zip | Date of Last Medical Exam | Work:
Email Address | Date of Last Eye Exam | Mobile:
Who can we thank for referring you to our office?

Primary Insurance Holder - Member Information

☐ *Same as above*

Member First Name | Middle Initial | Last Name | Ms.
Street Address | Vision Insurance Company: Vision Service Plan (VSP)
Member's Insurance ID (SSN)
City | Member's Date of Birth
State | Zip | Member's Relationship to Patient: Self

Secondary Insurance Holder - Member Information

Member First Name | Middle Initial | Last Name | Ms.
Street Address | Vision Insurance Company: Vision Service Plan (VSP)
Member's Insurance ID (SSN)
City | Member's Date of Birth
State | Zip | Member's Relationship to Patient: Self

Patient's Medical & Social History

Do you have any allergies to any medications? ☐ Yes ☐ No

List all your current medications

Medicine	Adverse Reaction	Medicine	Dosage	Reason

Are you pregnant/nursing? ☐ Yes ☐ No
Dou you wear glasses? ☐ Yes ☐ No
Do you wear contact lenses? ☐ Yes ☐ No
If yes, what type of contact lenses? ☐ Yes ☐ No

Do you drive? ☐ Yes ☐ No
Do you use tobacco products? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
Do you use illegal drugs? ☐ Yes ☐ No

If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
If yes to tobacco, how long?
If yes to alcohol, how often?
If yes to drugs, how often?

Have you ever been exposed or infected with:

Gonorrhea? ☐ Yes ☐ No
Syphilis? ☐ Yes ☐ No
HIV? ☐ Yes ☐ No
Hepatitis? ☐ Yes ☐ No

Family Medical & Ocular History

Please answer the following questions regarding your family history. Family includes parents, grandparents, siblings, and/or children. Living or deceased.

☐ Unknown Family History / Adopted

Blindness	☐ Yes	☐ No	Mother	Arthritis	☐ Yes	☐ No	Mother
Cataracts	☐ Yes	☐ No	Mother	Cancer	☐ Yes	☐ No	Mother
Crossed Eyes	☐ Yes	☐ No	Mother	Diabetes	☐ Yes	☐ No	Mother
Glaucoma	☐ Yes	☐ No	Mother	Heart Disease	☐ Yes	☐ No	Mother
Lazy Eyes	☐ Yes	☐ No	Mother	Hypertension	☐ Yes	☐ No	Mother
Macular Degeneration	☐ Yes	☐ No	Mother	Kidney Disease	☐ Yes	☐ No	Mother
Retinal Detachment	☐ Yes	☐ No	Mother	Lupus	☐ Yes	☐ No	Mother
Retinal Disease	☐ Yes	☐ No	Mother	Thyroid Disease	☐ Yes	☐ No	Mother

Account Responsibility Statement

I hereby understand that I am responsible for all vision services and material fees not covered by my insurance provider. All payment is due at the time of service or dispense.

Self

Signature of Account Responsible | *Date* | *Relationship to patient*

(Next page please!)

Patient Name: DOB:

Patient Review of Systems

Do you currently have or have you ever had any problems in the following areas?

Integumentary (Skin)	☐ Yes	☐ No	**Ears, Nose, Mouth, Throat**		
Neurologic			Allergies	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Hay Fevers	☐ Yes	☐ No
Migraines	☐ Yes	☐ No	Sinus Congestion	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Post-Nasal Drip	☐ Yes	☐ No
Eyes			Chronic Cough	☐ Yes	☐ No
Loss of Vision	☐ Yes	☐ No	Dry Throat/Mouth	☐ Yes	☐ No
Blurred Vision	☐ Yes	☐ No	**Respiratory**		
Distorted Vision or Halos	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Loss of Side Vision	☐ Yes	☐ No	Chronic Bronchitis	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No
Dryness	☐ Yes	☐ No	**Vascular**		
Mucous Discharge	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No Diet Controlled
Redness	☐ Yes	☐ No	Heart Pain	☐ Yes	☐ No
Sandy or Gritty Feeling	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Itching	☐ Yes	☐ No	Vascular Disease	☐ Yes	☐ No
Burning	☐ Yes	☐ No	**Gastrointestinal**		
Foreign Body Sensation	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Excessive Tearing/Watering	☐ Yes	☐ No	Constipation	☐ Yes	☐ No
Glare/Light Sensitivity	☐ Yes	☐ No	**Genitourinary** (Genitals, Kidney, Bladder)	☐ Yes	☐ No
Eye Pain or Soreness	☐ Yes	☐ No	**Bones/Joints/Muscles**		
Chronic Eye Infections	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Sties or Chalazions	☐ Yes	☐ No	Muscle Pain	☐ Yes	☐ No
Flashes in Vision	☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No
Floaters in Vision	☐ Yes	☐ No	**Lymphatic/Hematological**		
Tired Eyes	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Eye Infections	☐ Yes	☐ No	Bleeding Problems	☐ Yes	☐ No
Eye Injuries	☐ Yes	☐ No	**Endocrine** (Thyroid, other glands)	☐ Yes	☐ No
Eye Surgeries	☐ Yes	☐ No	**Psychiatric**	☐ Yes	☐ No

Patient Lifestyle and Occupation

What is your occupation?

What visual tasks are you concerned with?

☐ Distance ☐ Computer ☐ Reading

What are your hobbies?

☐ Reading ☐ Home repair Other:
☐ Musical Instrum. ☐ Woodworking
☐ Cooking ☐ Sewing

Which sports do you participate in (check all that apply)?

☐ Biking ☐ Baseball/Softball ☐ Swimming
☐ Golf ☐ Hiking/Camping ☐ Tennis
☐ Fishing ☐ Hockey ☐ Water sports
☐ Football ☐ Running/Track ☐ Working out

How many hours a day do you use the computer? Less than 1

Do you wear sunglasses when driving/outdoors? ☐ Yes ☐ No

Do you read without glasses? ☐ Yes ☐ No

Do you mind wearing glasses? ☐ Yes ☐ No

Are you interested in contact lenses? ☐ Yes ☐ No

Are you interested in LASIK or refractive surgery? ☐ Yes ☐ No

For Patients under 18 years of age / Child Developmental History

Was patient born full term?	☐ Yes	☐ No	Were there any complications during childbirth?	☐ Yes	☐ No
Were there any complications or delays in child's early development?	☐ Yes	☐ No	What grade level is your child at in school?		
Is your child performing at grade level?	☐ Yes	☐ No	Does your child enjoy reading books?	☐ Yes	☐ No

For Office Use

Date Reviewed	*Dr. Initials*	*Changes*		*Date Reviewed*	*Dr. Initials*	*Changes*