LOCK
FAMILY
EYE CARE

Patient Medical History Form

Today's Date _____

Patient Name (last)_____ **(first)**_____ ☐ **Male** ☐ **Female DOB:**_____

Address:_____ **City:**_____**State:**_____**Zip:**_____

Home Phone: (____**)**_____ **Alternative phone: (**____**)**_____

Vision Insurance:_____ **Medical Insurance:**_____

Primary of Insurance:_____ ☐ **Parent** ☐ **Spouse DOB:**_____

Medical Doctor:_____**Clinic:**_____**Last Medical Exam:**_____

Last Eye exam:_____ **Occupation:** _____

Do you have any allergies (seasonal/medical): ☐ no ☐ yes, please list_____
List all medications, vitamins and eye drops you are currently taking:_____
_____

Ocular History

What problem prompted your visit to Lock Family Eye Care today?_____

Does your vision alter your ability to do any of the following: ☐ read ☐ drive (day or night) ☐ work on computer

Do you wear glasses? ☐ no ☐ yes, current pair is how old?_____

Do you wear contact lenses? ☐ no ☐ yes, which brand?_____ power?_____

Do you like the comfort and vision through your contacts? ☐ yes ☐ no

Do you sleep in the contacts? ☐ no ☐ yes, how many consecutive days?_____

Ocular Health please indicate if you have or have had any of the following conditions

Condition	Yes	No	Comments (which eye)	Condition	Yes	No	Comments (which eye)
Glaucoma				Lazy Eye/Crossed eye			
Cataracts				Blurry Vision			
Cataract Surgery				Double vision			
Retinal Disease				Itching in eye			
Macular Degeneration				Eye Pain			
Eye Surgery				Eye Redness			
Eye Injury				Flashes/Floaters			

Social History please indicate if you use any of the following

Tobacco ☐ Yes ☐ No Amount/day?_____ ☐ Formerly, how many years? _____

Alcohol ☐ Yes ☐ No Amount/day?_____

Illicit Drugs ☐ Yes ☐ No Amount/day?_____