DRS. MILLER AND MILLER **Case History / General Eye Examination**

PATIENT NAME _____ DOB _____/_____/_____ Today's Date _____/_____/_____

MAILING ADDRESS _____CITY _____ ST,_____ ZIP _____

Home Ph _____ Work Ph _____ SS # _____ Email _____

PHYSICAL ADDRESS _____CITY _____ ST. _____ ZIP _____

Married / single / divorced / minor / other (Circle one) Medical Insurance? ☐ Yes or ☐ No Family Doctor _____

If minor: Responsible party _____ SS # _____ Work # _____ Home # _____

Date of last eye exam _____ Doctor _____ Glasses? Y / N Contacts? Y / N Other Treatment? _____

Reason for visit ☐ Blurry vision ☐ Double vision ☐ Tearing ☐ Eye discomfort ☐ Vision loss ☐ Red/irritated ☐ Other

Why did you select our practice? ☐ Word of mouth ☐ Referred by friend/relative ☐ Referred by doctor ☐ Yellow pages ☐ other

I have been diagnosed with or treated for (CIRCLE ALL THAT APPLY)
Cataract Glaucoma Macular Degeneration Other _____ Eye surgeries

I have a family member or relative diagnosed with or treated for (CIRCLE ALL THAT APPLY)
Cataract Glaucoma Macular Degeneration Other _____ Hypertension Diabetes Eye Problems

Occupation or School Grade _____ Name and address of employment:

Please check any medical problems listed below or check none if no problems with that system

CONSTITUTIONAL None ___
☐ developmental disability
☐ weight loss ☐ peri-birth problems
☐ fever ☐ premature
☐ fatigue
☐ trauma
☐ other

EARS, NOSE, THROAT None ____
☐ upper respiratory tract infection
☐ other

CARDIOVASCULAR None ____
☐ heart disease
☐ hypertension
☐ stroke
☐ vascular disease
☐ other

RESPIRATORY None ____
☐ smoker or recent ex-smoker
☐ asthma ☐ Tuberculosis
☐ bronchitis
☐ emphysema
☐ other

GASTROINTESTINAL None ____
☐ Crohn's
☐ colitis
☐ ulcer
☐ digestive/acid reflux
☐ other

ALLERGIC None ____
☐ allergy / atopy
☐ rheumatoid arthritis
☐ lupus
☐ other

MUSKULOSKELETAL None ____
☐ fibromyalgia
☐ muscular dystrophy
☐ arthritis/osteoarthritis
☐ ankylosing spondylitis
☐ other

INTEGUMENTARY None ____
☐ eczema
☐ rosacea
☐ psoriasis
☐ other

NEUROLOGICAL None ____
☐ multiple sclerosis
☐ epilepsy ☐ dyslexia
☐ migraines ☐ learning disabilities
☐ other

PSYCHIATRIC None ____
☐ depression ☐ ADD/ADHD
☐ panic disorder
☐ schizophrenia
☐ other

ENDOCRINE None ____
☐ non-insulin dependent diabetes
☐ insulin-dependent diabetes
☐ thyroid dysfunction
☐ hormonal dysfunction
☐ other

HEMATOLOGICAL None ____
☐ history of large volume blood loss
☐ leukemia ☐ Hepatitis C
☐ anemia ☐ HIV
☐ other

GENITOURINARY None___
☐ urinary tract infection
☐ kidney ailments
☐ STD – herpes, chlamydia
☐ other

LIST OF MEDICINES: _____

_____

_____

_____

Medicine allergies? _____ Doctors initials _____