

UPDATE – PERSONAL AND MEDICAL HISTORY
Ann K. Miyamura, O.D., Inc.

Name _____ Today's Date _____

Street _____ Date of Birth _____ Sex M F

City, State, ZIP _____ Email _____

Phone (Hm) _____ (Cel) _____ (Wk) _____

Primary Insured _____ SSN _____ Referred by _____

Physician name _____ Phone _____

Emergency contact _____ Phone _____ Relationship _____

Reason for eye exam: Glasses Contacts Both Other _____

If you wear contacts, what brand? _____ Power (if known) _____

Are you allergic to any medications? N Y If Yes, list _____

Are you pregnant and/or nursing? N Y

List any prescription or over the counter medications you are taking (including oral contraceptives, allergy medication, aspirin, vitamins / supplements, and eye drops) _____

Patient Eye History – Do you have any of the following? (check those you have)

<input type="checkbox"/> Burning	<input type="checkbox"/> Redness	<input type="checkbox"/> Dryness	<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Tearing
<input type="checkbox"/> Floaters	<input type="checkbox"/> Flashes of light	<input type="checkbox"/> Gritty sensation	<input type="checkbox"/> Double vision	<input type="checkbox"/> Headaches
<input type="checkbox"/> Sudden vision loss	<input type="checkbox"/> Light sensitivity	<input type="checkbox"/> Glare/halo at night	<input type="checkbox"/> Eyestrain	<input type="checkbox"/> Eye pain
<input type="checkbox"/> Eyelid twitching	<input type="checkbox"/> Lazy Eye	<input type="checkbox"/> Other (explain) _____		
<input type="checkbox"/> Injury/surgery, if so what kind and when? _____				

Family Medical History – Have any of your blood relatives (living or deceased) had any of the following:

(Mark M=mother, F=father, S=sibling, GP= grandparent)

Glaucoma	N	Y	Who _____	High Blood Pressure	N	Y	Who _____
Cataract	N	Y	Who _____	Diabetes	N	Y	Who _____
Lazy Eye	N	Y	Who _____	Macular Degeneration	N	Y	Who _____

Review of Systems – Do you have any of the following? (If so, please describe)

Neurological	N	Y	(MS, seizures, etc)	_____
Ear/Nose/Throat	N	Y	(sinus, ear infection etc)	_____
Cardiovascular	N	Y	(heart disease, etc)	_____
Respiratory	N	Y	(asthma, emphysema, etc)	_____
Gastro-Intestinal	N	Y	(ulcer, stomach etc)	_____
Genital-Kidney				
-Bladder	N	Y	(STDs, etc)	_____
Muscle – Bone				
-Joints	N	Y	(arthritis, etc)	_____
Skin	N	Y	(eczema, rosacea, etc)	_____
Psychiatric	N	Y	(anxiety, depression, etc)	_____
Endocrine	N	Y	(diabetes, thyroid, etc)	_____
Lymph-Blood	N	Y	(anemia, etc)	_____
Allergic				
-Immunologic	N	Y	(hayfever, lupus, food,etc)	_____