Personal Info & Medical History

(Please be thorough so we can focus your eye care.)

FEC-PMH-021023

Focused Eye Care
NASHUA & MILFORD

Name: _____ Date of Birth: _____

Your Primary Care Provider: _____

Personal Medical History	YES	NO
Developmental Disabilities		
Cancer (Type:)		
Fatigue Syndrome		
Hearing Loss		
Sinusitis		
Dry Mouth		
Laryngitis		
Multiple Sclerosis		
Epilepsy		
Cerebral Palsy		
Tumor/Stroke/CVA		
Migraine		
Autism Spectrum Disorder		
Depression		
ADD		
Anxiety		
Bipolar Disorder		
High Blood Pressure		
Heart Disease		
Vascular Disease		
Asthma		
Sleep Apnea		

Personal Medical History	YES	NO
Crohn's / Colitis		
Kidney Disease		
Pregnant/Nursing		
Arthritis		
Fibromyalgia		
Eczema		
Rosacea		
Psoriasis		
Diabetes Mellitus: Type 1 or 2		
Thyroid Dysfunction		
Large-volume blood loss		
High Cholesterol		
Autoimmune (Sjogren's, Lupus)		
Environmental Allergies		
Eye Turn/Lazy Eye		
Double Vision		
History of Eye Surgery		
Floaters/Flashes		
History of Eye Injury		
Glaucoma/Glaucoma Suspect		
Cataracts		
Other:		

Medications: (If you have a list, we can make a copy) including over-the-counter medications, eye drops or supplement: _____

_____

_____

Do you have any allergies to any medications? ☐ Yes ☐ No If yes, please list: _____

_____

Do you smoke? ☐ Yes ☐ Never ☐ Ex-Smoker (Year Quit: _____)

Do you wear glasses? ☐ Yes ☐ No Do you wear contact lenses? ☐ Yes ☐ No (If yes, please brings boxes or prescription)

Have you worn contact lenses in the past? ☐ Yes ☐ No

Family Medical History	Mother	Father	Brother	Sister	Son	Daughter
Glaucoma						
Cataracts						
Age-Related Macular Degeneration						
Cancer						
Diabetes						
High Blood Pressure						

Ethnicity: ☐ White ☐ Black ☐ Hispanic/Latino ☐ Native American/Inuit ☐ Asian ☐ Pacific Islander ☐ Mixed Race

Gender Identity: ☐ Female ☐ Male ☐ Other (Please self-describe) _____

Preferred Language: (If other than English): _____

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