Medical History Form

GROVE EYE CARE

Patient Information

Salutation: | First Name: | Middle Initial:

Sex: | Last Name: | Date: / /

Current Address: | City:

Zip Code:

Email: | Phone 1:

Employer: | Phone 2: /

Date of Birth: / / | Date of Last Eye Exam: / /

Referral Source: | Date of Last Medical Exam: / /

Name of Medical Doctor:

Doctors Phone:

Medical History

Do you have any allergies? Yes ☐ No ☐

If yes, please explain:

Please list any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

Please list any major injuries, surgeries and/or hospitalizations you have had:

Please continue on page 2

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GROVE EYE CARE

Medical History Continued

Please check any of the following conditions that you have had in the past:

Crossed Eyes:	☐	Prominent Eyes:	☐	Cataracts:	☐
Lazy Eye:	☐	Glaucoma:	☐	Eye Infection:	☐
Drooping Eyelid:	☐	Retinal Disease:	☐	Eye Injury:	☐

Do you wear glasses? Yes ☐ No ☐

If yes, how old is your current pair? _____

Do you wear contact lenses? Yes ☐ No ☐

If yes, how old is your corrent pair? _____

What type of contact lenses do you wear? Rigid ☐ Soft ☐ Extended Wear ☐

Are they comfortable? Yes ☐ No ☐

Family History

Please check any of the following conditions that you have had in the past and note any family history (parents, grandparents, siblings, children, both living and deceased) for the following conditions:

Blindness:	☐	Relationship:	_____
Cataracts:	☐	Relationship:	_____
Crossed Eyes:	☐	Relationship:	_____
Glaucoma:	☐	Relationship:	_____
Retinal Disease:	☐	Relationship:	_____
Retinal Detachment:	☐	Relationship:	_____
Arthritis:	☐	Relationship:	_____
Cancer:	☐	Relationship:	_____
Diabetes:	☐	Relationship:	_____
Heart Disease:	☐	Relationship:	_____

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GROVE EYE CARE

Family History Continued

Please check any of the following conditions that you have had in the past and note any family history (parents, grandparents, siblings, children, both living and deceased) for the following conditions:

High Blood Pressure: ☐ Relationship:

Kidney Disease: ☐ Relationship:

Lupus: ☐ Relationship:

Thyroid Disease: ☐ Relationship:

Crossed Eyes: ☐ Relationship:

If there are any other conditions not listed please explain here:

Social History

This information is kept strictly confidential. However, you may discuss your condition directly with the doctor if you prefer.

I would prefer to discuss my social history information directly with my doctor:

Do you drive? Yes ☐ No ☐

Do you have difficulty driving? Yes ☐ No ☐

If Yes, please explain:

Please continue on page 4

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GROVE EYE CARE

Social History Continued

Do you use tobacco products? Yes ☐ No ☐

If Yes, what type and how long?

Do you use drink alcohol? Yes ☐ No ☐

If Yes, what type and how long?

Do you use illegal drugs? Yes ☐ No ☐

If Yes, what type and how long?

Have you ever been exposed to or infected with Gonorrhea, Hepatitis, HIV, or Syphilis?

Yes ☐ No ☐

If Yes, please explain:

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GROVE EYE CARE

Review of Systems

Please check only those that apply if you currently, or have ever had any problems in the following areas:

Constitutional		**Eyes**	
Fever, Weight Loss/Gain:	☐	Loss of Vision:	☐
Integumentary		Blurred Vision:	☐
Skin:	☐	Distorted Vision/Halos:	☐
Neurological		Loss of Side Vision:	☐
Headaches:	☐	Dryness:	☐
Migraines:	☐	Mucous Discharge:	☐
Seizures:	☐	Redness:	☐
Ears, Nose, Throat, Mouth		Sandy or Gritty Feeling:	☐
Allergies/Hay Fever:	☐	Itching:	☐
Sinus Congestion:	☐	Burning:	☐
Runny Nose:	☐	Foreign Body Sensation:	☐
Post-Nasal Drip:	☐	Excess Tearing/Watering:	☐
Chronic Cough:	☐	Glare/Light Sensitivity:	☐
Dry Mouth:	☐	Eye Pain/Soreness:	☐
Endocrine	☐	Chronic Infection of Eye or Lid:	☐
Thyroid/Other Glands:	☐	Sties or Chalazion:	☐
Respiratory		Flashes/Floaters in Vision:	☐
Asthma:	☐	Tired Eyes:	☐
Chronic Bronchitis:	☐		
Emphysema:	☐		

Please continue on page 6

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GROVE EYE CARE

Review of Systems Continued

Please check only those that apply if you currently, or have ever had any problems in the following areas:

Vascular/Cardiovascular		Bones/Joints/Muscles	
Diabetes:	☐	Rheumatoid Arthritis:	☐
Heart Pain:	☐	Muscle Pain:	☐
High Blood Pressure:	☐	Joint Pain:	☐
Vascular Disease:	☐	**Lymphatic/Hematologic**	
Gastrointestinal		Anemia:	☐
Diarrhea:	☐	Bleeding Problems:	☐
Constipation:	☐	**Other**	
Genitourinary		Allergic/Immunologic:	☐
Genitals/Kidney/Bladder:	☐	Psychiatric:	☐

If you selected any of the above or have a condition not listed please explain here:

End of Medical History Form.
Please bring the completed form with you to your appointment at Grove Eye Care.

GROVE EYE CARE

3601 Grove Avenue
Richmond, VA 23221
(804) 353 - EYES (3937)

14431 Suite B
Sommerville Court
Midlothian, VA 23113
(804) 888 - 8998