Hodges Woodall Optometry Patient Medical History Form

Today's Date: _____ /_____ /_____

☐ Ms. ☐ Mrs. ☐ Mr. ☐Dr. Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed

Name: _____ Date of Birth: _____ /_____ /_____ Age:_____
(Last) (First) (Middle I.)

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

Phone/Cell: _____ Work Phone: _____ Email Address: _____

Vision Insurance:_____ Employer:_____ Occupation: _____

Parent/Legal Guardian: _____ Date of Birth: ____ /____ /____
(If Applicable) (Last) (First) (Middle I.)

Emergency Contact: _____ Phone/Cell: _____

Date of Last Eye Exam Date: _____ Name/location of eye doctor: _____

Date of Last Medical Exam: _____ Name/location of medical doctor: _____

Medical History

List all current medications, including eye drops and non-prescription medications: _____

_____

_____

_____

List all allergies (medication, food, seasonal allergies, latex, etc…): _____

_____

_____

List all major surgeries, including eye surgeries: _____

_____

Ocular History

Do you wear glasses? ☐Yes ☐No

Do you wear contacts? ☐Yes ☐No

If no but interested in contact lenses, please let our technicians know.

Family Ocular History

Does your parent, grandparent, sibling, or child have the following:

☐ Blindness
☐ Glaucoma
☐ Macular Degeneration
☐ Crossed or "lazy eye"
☐ Retinal Detachment

Personal Medical History: Please check if you have any of the following conditions:

Eyes/Ears/Nose/Throat
- ☐ Crossed or "lazy eye"
- ☐ Blindness
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Dry Mouth

General
- ☐ Sudden weight loss/gain
- ☐ Fever

Cardiovascular
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Atrial fibrillation (A Fib)
- ☐ Vascular Disease
- ☐ Sleep Apnea

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Current Smoker

Genitourinary
- ☐ Frequent Urination
- ☐ Kidney Disease
- ☐ Polycystic Ovarian Syndrome
- ☐ Currently Pregnant or Nursing
- ☐ Menopausal

Musculoskeletal
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Gout

Gastrointestinal
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel Syndrome

Dermatology
- ☐ Skin Cancer
- ☐ Dermatitis
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea

Neurological
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Dementia
- ☐ Seizures
- ☐ Migraines

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Metabolic Syndrome

Hematology/Lymphatic
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Anemia
- ☐ Bleeding Disorder

Other conditions not listed:

_____

_____

Please Turn Over

Record of Privacy Practice Notifications

I certify that I have been offered a copy of the office's Notice of Privacy Practices at my visit today:

Patient/ Legal Guardian Signature: _____ Date: _____