

EYE CARE ASSOCIATES OF ST. LOUIS
NEW PATIENT MEDICAL INFORMATION

NAME _____ DATE _____

AGE _____ REFERRED BY _____

PRIMARY CARE DOCTOR _____

EYE HISTORY

How long since your last eye exam? _____ How old are your present glasses? _____

Do you wear contacts? _____ Type? _____ How often do you replace them? _____

What lens care solution(s) do you use? _____ Do you ever sleep in your lenses? _____

Have you ever had **eye surgery**? Y N List type and dates:

Indicate if you have any of the following **eye symptoms** or **conditions**:

Loss of vision	Y	N	Distorted vision	Y	N	Double vision	Y	N
Cataract	Y	N	Glaucoma	Y	N	Floaters	Y	N
Lightning flashes	Y	N	Crossed or lazy eye	Y	N	Inflammation	Y	N
Styes	Y	N	Dry eyes	Y	N	Macular degeneration	Y	N

PAST MEDICAL HISTORY

List all major **medical problems, hospitalizations** or **illnesses** you have had:

List all **medications and eye drops** you take: _____

List any **allergies** to any **medication** or any other substance: _____

_____ NO KNOWN ALLERGIES

FAMILY HISTORY

Has anyone related to you had any of the following diseases? Give relationship:

Blindness	Y	N	Cataract	Y	N	Macular Degeneration	Y	N
Glaucoma	Y	N	Diabetes	Y	N	Retinal Detachment	Y	N

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed

Current Occupation _____

Alcohol Use Never Occasionally Frequently Daily Use of Tobacco No Yes _____ packs/day

Reviewed by:

Physician's signature _____ Date _____