Orange Park Eye Center

Drs. Abshire, Hoffman, Hoffman, Bowman, Reed, Hodges, Hodges, and Poole
Optometric Physicians

Patient Medical History Form

Name _____ Date of Birth _____/_____/_____
Height ____' ____"
Weight _____lbs
Diabetes: Yes _____ No_____
Insulin Dependent:
Yes_____ No _____

Diabetes Type:
Type One ____Type Two ____
Most Recent A1C: _____ %
Most Recent Blood Sugar Reading:
_____ mg/dl

Reason for visit:

- ❑ Blurred Vision Distance
- ❑ Blurred Vision Near
- ❑ Blurred Vision Near and Far
- ❑ Discharge from eye
- ❑ Double Vision
- ❑ Dryness
- ❑ Eyelid Swelling
- ❑ Eye Pain
- ❑ Flashes of Light
- ❑ Floaters
- ❑ Glare/Light Sensitivity
- ❑ Glasses Broken
- ❑ Itchiness
- ❑ Redness
- ❑ Tearing
- ❑ Other: _____

Please list any surgeries you have had including any eye surgeries:

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____
5. _____ Date _____
6. _____ Date _____

Please list any medications you are currently taking and what you are taking them for:

1. _____ Reason _____
2. _____ Reason _____
3. _____ Reason _____
4. _____ Reason _____
5. _____ Reason _____
6. _____ Reason _____
7. _____ Reason _____
8. _____ Reason _____
9. _____ Reason _____
10. _____ Reason _____

Please list any allergies to medications you have and the reaction to them:

1. _____ Reaction_____
2. _____ Reaction_____

3. _____ Reaction_____
4. _____ Reaction_____
5. _____ Reaction_____

Please indicate if you have a family history of any of the following diseases or disorders and the closest family member who has them. Please be sure to indicate if the family member is a maternal or paternal relation:

- ❑ Amblyopia (Lazy Eye) Family Member: _____
- ❑ Blindness Family Member: _____
- ❑ Cataract(s) Family Member: _____
- ❑ Color Blindness Family Member: _____
- ❑ Eye Tumors Family Member: _____
- ❑ Glaucoma Family Member: _____
- ❑ Macular Degeneration Family Member: _____
- ❑ Retinal Detachment Family Member: _____
- ❑ Strabismus (Eye Turn) Family Member: _____
- ❑ Arthritis Family Member: _____
- ❑ Cancer Family Member: _____
- ❑ Diabetes Family Member: _____
- ❑ Heart Disease Family Member: _____
- ❑ High Blood Pressure Family Member: _____
- ❑ Kidney Disease Family Member: _____
- ❑ Lupus Family Member: _____
- ❑ Stroke Family Member: _____
- ❑ Thyroid Disease Family Member: _____
- ❑ Other:_____ Family Member: _____

Current Occupation: _____

Do you drink alcohol?

- ❑ No
- ❑ Occasional
- ❑ 1 per day
- ❑ 2-3 per day
- ❑ 4+ per day

Do you smoke?

- ❑ No
- ❑ Occasional
- ❑ ½ pack per day
- ❑ 1 pack per day
- ❑ 1+ pack per day

Do you use nutritional supplements (vitamins etc.)?

- ❑ Yes
- ❑ No

Do you engage in regular exercise?

- ❑ Yes
- ❑ No

Marital Status:

_____Single _____Married _____Divorced _____Separated _____Widowed

How many hours a day do you use a computer, tablet, telephone, etc.?_____

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Optometric Physicians

Do you currently wear glasses? _____Yes _____No

If yes, what type of glasses do you use?

- ❑ Single Vision
- ❑ Bifocals
- ❑ Trifocals
- ❑ Progressives
- ❑ Over the Counter Readers

Do you currently wear contact lenses? _____Yes _____No

If yes, what brand of contact lenses are you currently wearing? _____

If no, are you interested in being fitted for contact lenses today? _____Yes _____No

If you have any other questions or concerns you would like the doctor to be aware of please list them here:

_____

_____

_____

_____

_____

_____

_____

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