Muirfield Eye Care

John F. Fanning, O.D.
Ame N. Cline, O.D.

Name _____ Todays Date: _____
Last First MI

Date of Birth: _____ SSN: _____ Gender: Male _____ Female _____

Address _____

City: _____ State: _____ Zip code: _____

Home Phone:_____ Cell Phone: _____ Work Phone:_____

Marital Status: Single ____ Married ____ Widowed ____ Divorced ____ Minor ____ Email: _____
(Only provide if you have read/signed HIPAA)

Employer: _____ Occupation:_____ Spouse's Name: _____

If Patient is a Minor

Parent / Guardian Name: _____ Phone: _____

Miscellaneous

List any previous surgeries with dates

_____

_____

_____

Are You Pregnant? ____ Yes ____ No

Are You Breast Feeding? ____ Yes ____ No

Do you wear glasses? ____ Yes ____ No

How old are your glasses? _____

Do you wear contact lenses? ____ Yes ____ No

What brand of contact lenses? _____

Are your contacts comfortable? ____ Yes ____ No

Are you interested in contact lenses? ____ Yes ____ No

Date of last physical: _____ Name of physician: _____

Do you use tobacco products? ____ Yes ____ No Estimated Height _____ Weight _____

How many hours do you perform near work? ____

Are you sensitive in bright sunlight? ____ Yes ____ No

How many hours per day do you use a computer? _____

Do you have trouble reading signs when driving at night? ____ Yes ____ No

How many hours are you outside? _____

Are you bothered by glare from

Overhead lighting? _____

A computer screen? _____

Oncoming headlights at night? _____

Family Health History

Mark YES or NO to each entry. If yes, list which family member including mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather)

Amblyopia (Lazy eye)	Yes / No	Relation: _____	Strabismus (Cross Eyes)	Yes / No	Relation: _____
Blindness/ vision impairment	Yes / No	Relation: _____	Arthritis	Yes / No	Relation: _____
Cataracts	Yes / No	Relation: _____	Cancer	Yes / No	Relation: _____
Glaucoma	Yes / No	Relation: _____	Diabetes	Yes / No	Relation:_____
Macular Degeneration	Yes / No	Relation: _____	Hypertension	Yes / No	Relation: _____
Retinal Detachment	Yes / No	Relation: _____	Stroke	Yes / No	Relation: _____
Cardiovascular disease	Yes / No	Relation: _____			

Please complete Both Sides of the Form OVER

6105 Memorial Drive Dublin, OH 43017 Phone (614) 793-8440 Fax (614) 793-8383
www.muirfieldeyecare.com

Patient's Name _____ Date of Birth: _____

Medical History

Do you currently have, or have you ever had, any of the following problems or conditions?

	Yes	No
Constitutional		
Fever, Weight Loss/Gain	____	____
Cardiovascular		
Heart Disease	____	____
High Blood Pressure	____	____
High Cholesterol	____	____
Stroke	____	____
Vascular Disease	____	____
Ears/Nose/Mouth/Throat		
Allergies	____	____
Sinus Congestion	____	____
Post Nasal Drip	____	____
Chronic Cough	____	____
Dry Mouth/throat	____	____
Respiratory		
Asthma	____	____
Chronic Bronchitis	____	____
Emphysema	____	____
Sleep Apnea	____	____

	Yes	No
Gastrointestinal		
Constipation	____	____
Crohn's Disease	____	____
Hepatitis A	____	____
Hepatitis B	____	____
Hepatitis C	____	____
Ulcer/ Reflux	____	____
Genito-Urinary		
Bladder / Genital / Kidney		
Herpes Simplex	____	____
Prostate	____	____
Musculoskeletal		
Joint/Muscle Pain	____	____
Osteo Arthritis	____	____
RA	____	____
Integumentary (skin)		
Skin Cancer	____	____
Skin Disease	____	____
Herpes Zoster/Shingles	____	____

	Yes	No
Neurological		
Headaches	____	____
Migraines	____	____
Multiple Sclerois	____	____
Gout	____	____
Seizures	____	____
Psychiatric		
Anxiety/Depression	___	___
Lymphatic - Hematologic		
Anemia	____	____
Bleeding Problems	____	____
Allergic / Immunologic		
Eczema	____	____
Hives	____	____
Lupus	____	____
Organ transplant	____	____

Diabetes: Type 1 ____ Type 2 ____ Date of Diagnosis _____ HbA1C _____ Average Blood Sugar (fasting)_____

Ocular History

Check any of the following that affect you:

Age-related macular degeneration	Yes / No	Injury to the eye region	Yes / No
Amblyopia (Lazy Eye)	Yes / No	Keratoconus	Yes / No
Blindness	Yes / No	Poor vision	Yes / No (circle below)
Cataracts	Yes / No	Near Distance Double vision	
Eyes burn, itch, water	Yes / No	Retinopathy	Yes / No
Eye Strain	Yes / No	Strabismus (Crossed Eyes)	Yes / No
Glaucoma	Yes / No	Tear film insufficiency (dry eyes)	Yes / No
History of refractive surgery	Yes / No	Other: _____	

Medications

List all CURRENT prescriptions, over-the-counter prescriptions, eye drops and dosages for each.

_____

_____

_____

_____

_____ No Medication

Medication Allergies

List any allergies you may have and reaction.

_____

_____

_____

_____

_____ No Medication Allergies

****

Doctor/Staff Use Only

Reviewed by _____ Date _____ Reviewed by_____ Date _____ Reviewed by_____ Date _____

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