Muirfield Eye Care

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

Name ____ Today's Date: ____________
Last First MI

Date of Birth: ________________ SSN: ______________________ Gender: Male _____ Female _____ Identify_____

Address ____

City: ______________________ State: ____________________ Zip code: ____________________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

Marital Status: Minor _____ Single _____ Married _____ Widowed _____ Divorced _____

Employer: ______________________ Occupation: ________________ Spouse's Name: ____________________

If Patient is a Minor
Parent / Guardian Name: ______________________________________ Phone: ________________________

****

Do you wear glasses? Yes / No
How old are your glasses? ____________________

Do you wear contact lenses? Yes / No
What brand of contact lenses? ________________________

Are you Pregnant? Yes / No

Estimated Height _________ Weight __________
Do you use tobacco products? Yes / No

Are your contacts comfortable? Yes / No
Are you interested in contact lenses? Yes / No

Are You Breast Feeding? Yes / No

Medications

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

____

____

____

____

____

____

_____ No Medication

Medication Allergies

List any allergies and reactions you may have.

____

____

____

____

____

_____ No Medication Allergies

Ocular History

Circle any of the following conditions that apply to you:

Age-related macular degeneration	Yes / No
Blindness	Yes / No
Eyes burn, itch, water	Yes / No
Glaucoma	Yes / No
Injury to the eye region	Yes / No
Strabismus (Crossed Eyes)	Yes / No

Other: ______________________________________

Amblyopia (Lazy Eye)	Yes / No
Cataracts	Yes / No
Eye Strain	Yes / No
History of refractive surgery	Yes / No (circle below)
Lasik PRK	
Poor vision	Yes / No (circle below)
Near Distance Double Vision	

Please complete Both Sides of the Form

Patient's Name ____ Date of Birth: ____________________

Medical History

Are you currently affected by or being treated for any of the following health concerns or conditions?

	Yes	No		Yes	No		Yes	No
Allergic / Immunologic	____	____	Genito-Urinary	____	____	Neurological		
Cardiovascular			Integumentary (skin)			**Headaches**	____	____
High Blood Pressure	____	____	**Skin Cancer**	____	____	Migraines	____	____
High Cholesterol	____	____	Skin Disease	____	____	Multiple Sclerosis	____	____
Stroke	____	____	Herpes Zoster/Shingles	____	____	Seizures	____	____
Vascular Disease	____	____	Lymphatic - Hematologic			Psychiatric		
Fever, Weight Loss/Gain	____	____	Anemia	____	____	Anxiety/Depression	____	____
Ears/Nose/Mouth/Throat	____	____	Bleeding Problems	____	____	Respiratory		
Gastrointestinal	____	____	Musculoskeletal	____	____	Asthma	____	____
						Sleep Apnea	____	____

Diabetes: Type 1 _______ Type 2 _______ Prediabetic _______

Date of Diagnosis: ______________ Current A1C: ____________ Average Blood Sugar (fasting): ________________

Miscellaneous

List any previous surgeries with dates

____
____
____
____
____
____

Name of primary care physician: _______________________________

Date of last physical: ____

Physician's phone number: ____________________________________

****

Family Health History

Circle YES or NO to each entry. If yes, list which biological family member (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: ___________			

****

Doctor / Staff Use Only

Reviewed by ______ Date _______ Reviewed by_______ Date _______ Reviewed by_______ Date _______