MOUNTAINEER VISION CENTER, PLLC

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http://www.mvcpllc.com

PATIENT'S NAME: _____ DATE: _____

MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

CONDITION	YES	NO	MEDICATIONS
HYPERTENSION			
HEART DISEASE			
STROKE			
DIABETES			
THYROID DISEASE			
ARTHRITIS OSTEOATHRITIS RHEUMATOID			
SINUSITIS			
EMPHYSEMA			
ASTHMA			
KIDNEY DISEASE			
HEADACHE			
HEAD INJURY			
LIVER DISEASE			
SEIZURES/TREMORS			
LUPUS			
ROSACEA			
HIGH CHOLESTEROL			
CANCER			

DO YOU HAVE ANY OF THE FOLLOWING EYE CONDITIONS?

CONDITION	YES	NO	HOW LONG
GLAUCOMA			
MACULAR DEGENERATION			
CATARACTS			
RETINAL DETACHMENT			
EYE INJURIES			
EYE SURGERIES			
BLINDNESS			
LAZY EYE			

DO ANY OF YOUR FAMILY MEMBERS HAVE ANY OF THESE MEDICAL CONDITIONS?

CONDITION	YES	NO	WHICH FAMILY MEMBER
HYPERTENSION			
HEART DISEASE			
STROKE			
DIABETES			
GLAUCOMA			
CATARACT			
RETINAL DETACHMENT			
EYE SURGERIES			
BLINDNESS			
MACULAR DEGENERATION			

DO YOU HAVE DRY EYES? **YES** **NO**

DO YOU HAVE AIRBORNE ALLERGIES? **YES** **NO** **LIST ALL ALLERGY MEDICATIONS BELOW:**

ARE YOU ALLERGIC TO ANY MEDICATIONS? **YES** **NO** **IF YES, PLEASE LIST BELOW:**

PLEASE LIST THE REASON(S) FOR YOUR VISIT TODAY:

DO YOU WANT (CIRCLE ONE) **GLASSES** **CONTACTS** **BOTH**

ARE YOU PREGNANT? **YES** **NO**
DO YOU SMOKE? **YES** **NO**
DO YOU USE BIRTH CONTROL? **YES** **NO**

PATIENT INFORMATION

FIRST NAME: _____ **MI:** _____ **LAST NAME:** _____

ADDRESS: _____ **APT #** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE: _____**WORK PHONE:** _____ **CELL PHONE:** _____

EMAIL ADDRESS: _____

MARITAL STATUS: **SINGLE** **MARRIED** **LEGALLY SEPARTED** **DIVORCED** **WIDOWED**

GENDER: **MALE** **FEMALE** **DATE OF BIRTH** _____ **AGE:** _____

SOCIAL SECURITY NUMBER: _____ **OCCUPATION:** _____

EMPLOYER: _____

FAMILY DOCTOR: _____ **FAMILY DOCTOR PHONE #** _____

EMERGENCY CONTACT: _____ **PHONE #:** _____

INSURED/GUARANTOR INFORMATION (IF NOT SELF OR PATIENT IS A MINOR)

FIRST NAME: _____ **MI:** _____ **LAST NAME:** _____

ADDRESS (IF DIFFERENT THEN PATIENT)

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL:** _____

EMPLOYER: _____ **DATE OF BIRTH:** _____