Four Corners EyeCare
7 North Main Street
Honeoye Falls, NY 14472
(585)624-2585

PATIENT MEDICAL HISTORY

To better serve up, please complete both pages of this form as accurately and completely as possible. Please print all of your answers. Thank you.	
Name:	Today's Date: _____/_____/_____
Date of Birth: _____/_____/_____	

Allergies	**Yes**	**No**
Are you allergic to any drugs or foods? If Yes, please list all known allergies in the spaces below.		

Medications	**Yes**	**No**
Are currently taking any medications? If Yes, please list all medications, including eye drops and non-prescription drugs, below.		

Eye / Heart Surgery	**Yes**	**No**
Have you ever had surgery? If Yes, please list date and types of surgery below.		

Signature of Patient or Guardian ____

Please fill out both pages of this form before signing it

Main Street EyeCare

PATIENT MEDICAL HISTORY

Have you or a family member (parent, grandparent, brother, sister, or child) ever had any of the following? **Please check either "Yes" or "No" for each condition.**	**You**		**Family Member**	
	Yes	**No**	**Yes**	**No**
Glaucoma?				
Eye Injury or Surgery?				
Crossed / Lazy Eyes?				
Dry Eyes? (e.g. tearing, stinging, redness)				
Blindness?				
Diabetes?				
High Blood Pressure?				
Stroke?				
Thyroid Disease?				
Heart Problems? (e.g. chest pain, irregular heart beat, heart disease, heart attack)				
Anemia, Bleeding or Lymph Problems?				
Respiratory problems? (e.g. shortness of breath, wheezing, cough, asthma, TB, bronchitis)				
Gastrointestinal problems? (e.g. heartburn, abdominal pain, diarrhea, vomiting)				
Urinary / Genital problems? (e.g. pain or discomfort, blood in urine)				
Skin problems? (e.g. rashes, excessive dryness, rosacea)				
Musculoskeletal problems? (e.g. muscles aches, joint pain, swollen joints, arthritis)				
Neurological problems? (e.g. numbness, weakness, headaches, paralysis, seizures)				
Psychiatric problems? (e.g. depression, anxiety)				
Ear, nose or mouth / throat problems? (e.g. hearing loss, sinus problems, sore throat)				
Cancer?				
Liver Disease?				
Autoimmune Diseases? (e.g. Lupus, Crohn's disease)				
HIV / AIDS				
Fever for more than 10 days; unexpected weight loss or gain, fatigue				
Other conditions not mentioned above?				
Do you use tobacco?				
Do you drink alcohol?				
Other? If yes, explain.				