Berks Eye
Physicians & Surgeons, Ltd.

MEDICAL HISTORY FORM

Patient _____ Date _____ Acct # _____

Please circle (Yes *or* No) for each of the following medical conditions. If yes, please provide year of on-set. (If completed by someone other than the patient, give name & relationship) _____

Y N	High Blood Pressure		Y N	Hard of Hearing	
Y N	Diabetes		Y N	Stroke	
Y N	Heart Disease		Y N	High Cholesterol	
Y N	Heart Attack		Y N	Migraine	
Y N	Irregular Heart Beat		Y N	Blood Disorder	
Y N	Carotid Artery Disease		Y N	Lung Disorder	
Y N	Osteo/Rheumatoid Arthritis		Y N	Thyroid Disorder	
Y N	Rheumatic Fever as a Child		Y N	Intestinal Disorder	
Y N	Hepatitis		Y N	Psychiatric Disorder	
Y N	Cancer		Other:		

SURGICAL HISTORY: Please list surgeries you have had to **ANY** body part, along with the approximate year of surgery: _____

Do you have any **METALLIC** devices/pieces in your body? □ **Yes** □ **No.** If yes, please provide location: _____

ALLERGIES (Medications, Latex, Environmental): _____

FAMILY HISTORY: (Parent, Grandparent, Sibling or Child)

Y N	Blindness (cause?)		Y N	"Lazy Eye"	
Y N	Macular Degeneration		Y N	Diabetes	
Y N	Glaucoma		Y N	High Blood Pressure	

SOCIAL HISTORY: Lifestyle can also affect our health in many ways.
Do you drive? Y N Do you use tobacco? Y N Do you use alcohol? Daily Occasionally Never
Do you work with metals, fumes, chemicals or in a dusty environment? Y N Do you wear safety glasses? Y N
Do you work or have a hobby that you might need visual correction for at specific distances? Y N
Is there another adult living in your household? Y N

OCULAR HISTORY: (*New patients only)*

Y N	Eye Injury (Describe)	
Y N	Dry Eyes If yes, how treated?	
Y N	Contact Lenses If yes: Soft *or* Hard? Daily *or* Extended wear? Still wearing? Yes Not since	
Y N	Retinal Disorder or Surgery	
Y N	Cornea Disorder or Surgery	
Y N	Eyelid Disorder or Surgery	
Y N	Eye Muscle Disorder ("Lazy Eye") or Surgery	
Y N	Cataract (current) or Cataract Surgery	
Y N	Glaucoma or Glaucoma Surgery/Laser	

Other: _____

MEDICATIONS: (*New patients only)* Please list all medications taken regularly on the back of this form.

Patient/Guardian Signature: _____ Date: _____

************************REVIEWED AS DATED BELOW************************

Date _____ by _____/_____ Date _____ by _____/_____
Date _____ by _____/_____ Date _____ by _____/_____