Berks Eye
Physicians & Surgeons, Ltd.

MEDICAL HISTORY FORM

Patient_____Date_____Date of Birth: _____

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	Type 1 Diabetes	_____	Y N	Stroke	_____
Y N	Type 2 Diabetes	_____	Y N	High Cholesterol	_____
Y N	Heart Disease	_____	Y N	Migraine	_____
Y N	Heart Attack	_____	Y N	Blood Disorder	_____
Y N	Irregular Heart Beat	_____	Y N	Lung Disorder	_____
Y N	Carotid Artery Disease	_____	Y N	Thyroid Disorder	_____
Y N	Osteo/Rheumatoid Arthritis	_____	Y N	Intestinal Disorder	_____
Y N	Rheumatic Fever as a Child	_____	Y N	Psychiatric Disorder	_____
Y N	Hepatitis	_____	Y N	Seizures/Seizure Disorder	_____
Y N	Cancer	_____	Other:	_____	

MEDICATIONS: Please list all medications taken regularly on the back of this form.

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

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: _____

Patient/Guardian Signature:_____ **Date:**_____

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

Date _____by_____/_____ Date _____by _____/_____
Date _____by_____/_____ Date _____by _____/_____