MATT WEAVER, O.D.

History Form

(please print)

Today's date:_____

Patient's Last Name:	**First:**	**Middle:**	**Birth Date:** / /	**Age:**

Date of last exam: / / / **From Dr.** _____

Basic Exam ☐ **Dilated Exam** ☐ **Contact Lens Exam** ☐

Dilation gives the best views of the retinas and is necessary for diabetics

DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE ANY OF THE FOLLOWING CONDITIONS?

	Self	Relative	None
Diabetes			
High Blood Pressure			
Heart Disease			
Cancer			
Glaucoma			
Macular Degeneration			

Primary Care Provider:

FOR YOURSELF

	Yes	No
Eye Surgery		
Eye Injury		
Double Vision		
Cataracts		
Frequent Headaches		
Pregnant		
Tobacco Use If yes, how much? _____ How long? _____		
Alcohol Use If yes, how much? _____ How long? _____		

FOR YOURSELF, DO YOU HAVE ANY PROBLEMS WITH:

	Yes	No	If yes, explain
Ears, nose, throat, or mouth			
Stroke			
Respiratory			
Gastrointestinal			
Musculoskeletal (i.e. arthritis)			
Neurological			
Psychiatric			
Endocrine (thyroid, etc.)			
Blood disorders			
Allergies (medicine or environmental)			

Current medications (please list or receptionist can make a copy):

_____

_____

Are you currently using any eye drops, prescription or over-the-counter? Please list:

_____

Signed: _____