

Battle Creek Eye Clinic
7055 Tower Rd. Suite E
Battle Creek, MI 49014
269-968-8183

Medical History

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Phone (H) _____ (C) _____ (W) _____
Date Of Birth _____ SSN _____
Occupation _____ Employer _____
Date of Last Eye Exam _____
Whom may we thank for referring you (friend, yellow pages, etc.) _____

Medical History

Diabetes Y/N Type _____ Date of Diagnosis _____

Allergies Yes/No Allergic to _____

Medication Allergies _____

Do you use over the counter drops (i.e. Visine A, Visine AC, Opcon, A, etc.) YES/NO

Current Medications (list meds, dose, reason for taking meds, how long you've been on the medications)

Other Health Problems _____

Previous Operations Y/N Kind _____ When _____

Do you use cigarettes/tobacco Y/N Alcohol Y/N Other Substances Y/N

Name of Family Dr. _____ Last Visit _____

Last Tetanus Shot _____

Family History

High Blood Pressure Y/N Relationship _____

Diabetes Y/N Relationship _____

Glaucoma Y/N Relationship _____

Macular Degeneration Y/N Relationship _____

Retinal Detachment Y/N Relationship _____

Cataracts Y/N Relationship _____

Other Eye or Health Conditions YES/NO What kind? _____

Personal Eye Information

Have you had any eye operations? Y/N Type _____ Date _____

Have you had any eye injuries? Y/N Type _____ Date _____

Do you have glaucoma? Y/N Cataracts? Y/N

Medical History

Other Eye Problems Y/N What Kind _____
Do you wear glasses? Y/N Contacts? Y/N Type _____
Are you interested in contacts? Y/N
Email Address for Newsletters _____

Bones/Joints/Muscles

Y N Rheumatoid Arthritis
Y N Muscle Pain
Y N Joint Pain
Y N Allergic/Immunologic
Y N Psychiatric

Constitutional

Y N Fever, Weight loss/gain
Y N Integumentary (skin)
Y N Neurological
Y N Headaches
Y N Migraines
Y N Seizures
Y N Chronic Infection
Y N Sties or Chalazion
Y N Flashes/Floaters
Y N Tired Eyes

Ears, Nose, Mouth, Throat

Y N Allergies/Hay Fever
Y N Sinus Congestion
Y N Runny Nose
Y N Post-Nasal Drip
Y N Chronic Throat/Mouth

Endocrine

Y N Thyroid/Other Glands
Y N Diabetes

Eyes

Y N Loss of Vision
Y N Blurred Vision
Y N Loss of Side Vision
Y N Double Vision
Y N Dryness
Y N Mucous Discharge
Y N Redness
Y N Sandy or Gritty Feeling
Y N Itchy
Y N Burning
Y N Foreign Body Sensation
Y N Excess Tearing/Watering
Y N Glare/Light Sensitivity
Y N Eye Pain or Soreness
Y N Flashes/Floaters

Gastrointestinal

Y N Diarrhea
Y N Constipation

Respiratory

Y N Asthma
Y N Chronic Bronchitis
Y N Emphysema

Vascular/Cardiovascular

Y N Heart Pain
Y N High Blood Pressure
Y N Vascular Disease

Signature _____ Date _____
Signature _____ Date _____
Signature _____ Date _____
Signature _____ Date _____
Signature _____ Date _____
Signature _____ Date _____