ANDOVER EYE

Doctors Park II | 138 Haverhill Street, Suite 104 | Andover, MA 01810
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PATIENT HISTORY RECORD

Date: _____

Patient Name: _____ Birth Date: _____

Personal Physician: _____ Occupation:_____

Referring Physician: _____

What brings you in to see us today? _____

Date of last eye exam?_____ Previous Eye Physician:_____

Please answer the following questions about **your** medical status and history:

Please circle any of the following that you are being treated for or have been treated for in the past:

Diabetes	Strabismus	Retinal Disease
High blood pressure	Cataract	Macular degeneration
Tuberculosis	Cancer	Blindness
Lupus	Glaucoma	Heart disease
Amblyopia	Serious eye injury	Arthritis /Rheumatoid
Other: _____	Other: _____	

Have you ever had any eye surgery or other surgery?

No ___ If YES, Please explain: _____

Do you take **medications** or vitamin supplements?

No ___ If YES, Please complete attached medication form.

Do you take any **eye drops** or **medication for your eyes**?

No ___ If YES, Please list: _____

Do you have any drug or food allergies?

No ___ If YES, Please explain: _____

Please circle any of the following problems that you are currently experiencing, or have experienced:

Vision changes: Gradual//Sudden	Irregular Heartbeat	Anxiety
Eye Irritation	Abdominal	Allergies
Muscle aches	Skin rashes	Heartburn
Joint Pain	Excessive dry skin	Headaches
Fatigue	Weakness//Numbness	Chronic fever
Hearing loss	Coughing/Wheezing	Chest pain
Sinus Problems	Shortness of breath	Unexpected weight gain or loss

Has anyone in your family ever been diagnosed with any of the following? Please circle.

Diabetes	Strabismus	Retinal Disease
High blood pressure	Cataract	Macular degeneration
Tuberculosis	Cancer	Blindness
Lupus	Glaucoma	Heart disease
Amblyopia	Serious eye injury	Arthritis/Rheumatoid
Other: _____	Other: _____	

Do you smoke? If Yes, how much? _____

Drink alcohol? If Yes, how much? _____

Do you wear glasses? If Yes: Reading or Distance No_____

Do you wear contact lenses? No: _____ Yes: _____

If Yes, which type? ____ Soft Lenses _____Rigid gas permeable lenses ____ Hard lenses

PLEASE BRING BRAND, BASE CURVE & DIAMETER AND PRESCRIPTION INFORMATION (SEE YOUR CONTACT LENS BOX) TO YOUR VISIT

How often do you throw them away? _____

How many years have you worn contact lenses? _____

Do you sleep in your contacts? ____ No ____ Yes: How often? _____

Do you wish to be fit for contact lenses or renew your contact lens prescription? ____ No ____Yes

IMPORTANT: For a **Contact Lens Fitting** or **Contact Lens Prescription Renewal**, there will be a fitting charge in addition to the standard examination fee that may or may not be covered by your insurance plan. Patient is responsible for any of these charges not covered by your insurance. These fees will be due at the time of service. Please speak to your insurance provider regarding complete details on this.

Please be sure to bring your list of Medications, Glasses and/or Contact Lenses with you.

Please bring sunglasses with you, as your eyes will be dilated.

Signature: _____ Date: _____

Each doctor is independent. Andover Eye Associates, Inc. is a billing and administrative agency.