3D Optometry Dr. Thomas Mirabile

PATIENT HISTORY FORM

Last Name _____ First Name _____ MI _____ Date _____

Birth Date _____ Male _____ Female _____ SS # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Employer/Occupation _____ Insurance _____

VISUAL AND MEDICAL HISTORY

Date of last eye exam _____ By whom _____

Reason for today's visit _____

Contact lens type _____ Who is your family Doctor? _____

Please check any condition that applies to yourself or any members of your immediate family:

	Self	Family		Self	Family
Diabetes			Retinal detachment		
High blood pressure			Eye surgery		
Cataracts			Lazy Eye		
Heart Problems			Double Vision		
Respiratory Problems			Macular Degeneration		
Thyroid Problems			Head/Eye Injury		
Glaucoma			Headaches		
Loss of Vision					

Do you have problems with any of these systems? (Please Circle)

Gastrointestinal	Y/N	Nervous	Y/N	Allergic/Immunologic	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/Lymph	Y/N

Please explain _____

Medications you are currently taking? _____

_____

What allergies do you have, if any? _____

List sports/hobbies you participate in _____

Please answer yes or no to the following questions:

Do you work on a computer? _____ Do you have difficulty driving at night? _____

Do you have trouble with glare? _____

Who may we thank for referring you? _____ Email: _____