

DUTCHESS OPTOMETRY, LLP

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Medical History Record

Date _____

Patient's Name (please print) _____ Birth Date _____ M or F _____

Street Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ SS# _____

Type of Insurance _____ Ins. ID# _____

Employer _____ Occupation _____

Are you under 18 ? If yes, parent or guardian name: _____

Are you a student ? Yes ___ No ___ Name of school ? _____ Grade _____

Emergency Contact _____ Phone Number _____

Approximate date of last eye exam _____

Personal Medical Information: Do you have problems with any of these systems ? If yes, please check box.

- | | | |
|---|--|---|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Mental | <input type="checkbox"/> Endocrine (glands) |
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Nervous System | <input type="checkbox"/> Blood/Lymph |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Allergic/Immunologic |

Are you in good health ? Yes ___ No ___

Any allergic reactions to medications or other substances ? Yes ___ No ___

If yes, please list _____

Name of primary physician _____ Phone number _____

Please check YES or NO

Do you smoke ? Yes ___ No ___ How much ? _____

Do you drink alcohol ? Yes ___ No ___ How much ? _____

Do you take medications ? Yes ___ No ___ Please list names & how often _____

Do you use other substances ? Yes ___ No ___

Do you have family history of any of the following ? If Yes, please check box.

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Macular Degen. | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts | |

Check the boxes if any of the following apply to you:

- | | | |
|--|--|--|
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Currently wear glasses | <input type="checkbox"/> Would like to be fit for contacts |
| <input type="checkbox"/> Eye Surgeries in past | <input type="checkbox"/> Currently wear contacts | |
| <input type="checkbox"/> Eye Injuries in past | | |

Any eye/vision problems at this time ? Please explain _____

What is the reason for todays visit ?

Do you work on a computer ? Yes ____ No ____ Laptop or desktop ? _____ How many hrs per day ? ____

Hobbies / Interests / Sports _____

Whom may we thank for referring you to our office ? _____

Are any of your family members patients of ours ? If so, please list _____

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature _____ Date _____