MALARA EYECARE
& Eye Spa

8395 Oswego Road (Rte. 57), Liverpool, NY
6950 East Genesee Street, Fayetteville, NY
www.DrMalara.com

Today's Date: ___ / ___ / ___

Medical History Questionnaire

Full Name: _____ M / F Birth Date: _____ / _____ / _____

Title: Mr. Mrs. Miss Ms. Dr. Other *Marital Status:* Single Married Widowed Divorced Separated

Address: _____ Social Security #: _____

_____ Home Phone: _____

Email: _____ Cell Phone: _____ Texting **Y** or **N**

Communication Preference: ☐ Email ☐ Postal ☐ Phone

Responsible Party if different: _____ ***Billing Address if different:*** _____

Phone: _____ ***Relationship to patient:*** _____ _____

Medical Insurance: _____ Vision Insurance: _____

Place of Employment: _____ Work Phone: _____

If Married, Name of Spouse: _____ Spouse's place of work: _____

Name of Medical Doctor: _____ Phone: _____ Pharmacy : _____

Name of Previous Eye Doctor: _____ Pharmacy Address: _____

Whom may we thank for referring you: _____ Pharmacy Phone: _____

*** PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED***

We accept Visa, MasterCard, Discover, American Express, Care Credit, and Debit Cards

Ocular / Medical History

Do you wear glasses? ☐ No ☐ Yes How old are your eyeglasses? _____ Are you getting glasses today? ☐ No ☐ Yes

Do you wear contact lenses? ☐ No ☐ Yes If yes, what type? RGP / Soft Do you sleep in them? ☐ No ☐ Yes

How frequently do you replace them? _____ Solution Brand? _____ Are they comfortable? ☐ No ☐ Yes

Are you interested in contact lenses today? ☐ No ☐ Yes Do you wear Safety Glasses for home/work? ☐ No ☐ Yes

Are you currently experiencing any of the following problems with your eyes? **Check the box if "Yes."**

- ☐ Blurred Vision
- ☐ Loss of Vision
- ☐ Flashes
- ☐ Floaters
- ☐ Double Vision
- ☐ Dizziness
- ☐ Tired Eyes
- ☐ Redness
- ☐ Eye Pain or Soreness
- ☐ Dryness
- ☐ Excess Tearing / Watering
- ☐ Foreign Body Sensation
- ☐ Burning
- ☐ Itching
- ☐ Halos / Glare
- ☐ Light Sensitivity

Have you been diagnosed with any of the following ocular problems? **Check the box if "Yes."**

- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Drooping eyelid
- ☐ Other: _____

List any **medications** you are currently taking (include oral contraceptives, aspirin, over the counter, and home remedies):

_____

_____

_____

Are you **allergic** to any medications? ☐ No ☐ Yes If yes, please explain: _____

_____

List all major **surgeries** and / or **hospitalizations** you have had: _____

_____

Please turn this form over and complete side two

Family History Please note any family history (parents, grandparents, siblings, children):

	Relation to You		Relation to You
Blindness (How?)		Cancer	
Cataract		Diabetes	
Crossed Eyes		Heart Disease	
Glaucoma		High Blood Pressure	
Macular Degeneration		Kidney Disease	
Retinal Detachment		Lupus	
Rheumatoid Arthritis		Thyroid Disease	

Preferred Language: ☐ English ☐ Spanish

Race: ☐ Native Amer/Alaskan
☐ Asian
☐ African Amer.
☐ Hispanic
☐ Native Hawaiian/Other Pacific Island
☐ White

Ethnicity: ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Isl.
☐ Non Hispanic/Latino

Review of Systems Please check the box beside any problem you currently have in the following areas:

Allergic / Immunologic ☐ **All Normal**
☐ Allergy / Hayfever

Cardiovascular / Cardiac ☐ **All Normal**
☐ Arteriosclerosis
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol

Constitutional ☐ **All Normal**
☐ Fever
☐ Weight Loss / Gain (circle)

Ears, Nose, Mouth, Throat ☐ **All Normal**
☐ Sinus Congestion
☐ Dry Throat / Mouth

Endocrine ☐ **All Normal**
☐ Diabetes - Blood Sugar_____ A1C___ Years___
☐ Thyroid Disease
☐ Chronic Fatigue

Gastrointestinal ☐ **All Normal**
☐ Diarrhea
☐ Constipation
☐ Ulcers
☐ Reflux

Genitourinary ☐ **All Normal**
☐ Kidney Disease
☐ Ovarian / Uterine Cancer
☐ Prostate Cancer
☐ Polycystic Ovarian Syndrome (PCOS)

Hematologic / Lymphatic ☐ **All Normal**
☐ Anemia
☐ Bleeding Problems
☐ Breast Cancer

Integumentary (Skin) ☐ **All Normal**
☐ Skin Cancer
☐ Rashes
☐ Easy Bruising

Musculoskeletal ☐ **All Normal**
☐ Rheumatoid Arthritis
☐ Muscle Pain
☐ Joint Pain
☐ Fibromyalgia
☐ Osteoporosis

Neurological ☐ **All Normal**
☐ Headaches/Migraines
☐ Dizziness/Vertigo
☐ Seizures
☐ Stroke

Psychiatric ☐ **All Normal**
☐ Anxiety
☐ Depression
☐ Memory Loss
☐ Hallucinations
☐ ADD/ADHD
☐ Autism
☐ Alzheimer's
☐ Dementia

Respiratory ☐ **All Normal**
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Chronic Cough
☐ COPD

If you checked any of the above boxes or have a condition not listed, please explain further:_____

_____

_____

Are you pregnant and / or nursing? ☐ Yes ☐ No

Eye/Face Aesthetic:

Are you bothered by: Dry Eye ___ Smile Lines ___ Crow's Feet ___ Facial Wrinkles ___
Would you be interested in an aesthetics consult? Y / N

Social History *This information is kept strictly confidential. However,* ***you may discuss this portion directly with your doctor if you prefer.*** *Please check the following box if you wish to discuss your Social History directly with your doctor:* ☐

Do you drive? ☐ Yes ☐ No If yes, describe any visual difficulty while driving: _____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long: _____ Packs:_____ Years_____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long:_____ Per Day:_____ Only Social:____

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long:_____

Indicate by checking the box if you have been infected with or exposed to: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ MRSA

Signature:_____ Date:_____