Meyer Eyecare
13114 Western Ave
Blue Island, IL 60406
Phone (708) 388-1228
FAX (708) 810-9726
www.meyereyecare.com

Patient Health History

Please provide all information. **Date:** _____

Patient Name:		Date of Birth:
Patient Address:		
Home Phone:	Cell Phone:	Gender:
Primary Care Physician:	Email:	
Reason for Last Visit:	How long since your last visit?	
Last Eye Doctor:	How long since your last eye exam?	
Pharmacy & Location:		
Pharmacy Phone:	Occupation:	

Contacts / Emergency Contacts

Name/ Relationship/ Address	Title/Specialty/ Relationship	Emergency Contact YES NO	Release Medical Info YES NO	Phone Numbers/ Fax

Medications

List all prescriptions, over the counter and herbal medications.

Name	Dose/Strength

Allergies

Allergy	Onset Date	Reaction

Personal Medical History

Medical Condition / Additional Details

Height in inches:	Weight in lbs:

Personal Ocular History	
Ocular Condition / Additional Details	
Type of contact lenses you currently use (gas permeable, soft daily, extended)	

Surgical History	
Date	**Procedure / Surgeon**

Family Medical History	
Family Member	**Medical Condition / Additional Details**
Father	
Father	
Mother	
Sister	
Grandmother - Maternal	
Grandfather - Maternal	
Grandmother - Paternal	
Grandfather - Paternal	
Mother	
Father	

Tobacco Status / History		
Current Tobacco Status	**Age Began**	**Year From – Year To**

Select your tobacco status below if the above status is blank or incorrect:

- ☐ Current everyday smoker
- ☐ Current some day smoke
- ☐ Former smoker
- ☐ Heavy tobacco smoker
- ☐ Light cigarette smoker (1-9 cigs/day)
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Unknown if ever smoked

Signature Required

The information on this Patient Health History Form is current and correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Meyer Eyecare of any changes in medical status. I also consent to have my prescriptions sent electronically to the portal.

Patient's Signature (or person authorized to sign for patient) _____ **Date** _____