Mitchell Eye Institute, P.C.
Clinical History Form

PATIENT NAME:_____ **DATE:**_____

In an effort to spend as much quality time with you during your exam as possible, we would appreciate you filling in as much of the following information as possible while you are waiting OR before you arrive.

CURRENT MEDICATIONS **Dose** **Reason for taking it**

_____

_____

_____

_____

_____

CURRENT PHARMACY:_____**LOCATION**_____**PHONE#**_____

Your height? _____ **Current weight?** _____**Most Recent Blood Pressure ?**_____

Do you smoke? _____ **If you used to, when did you quit?** _____

Do you have any medical conditions or have you had any surgery? (use reverse side if necessary)

_____

_____

_____

Please check if you are experiencing any of the following symptoms:

Fever: _____ **Weight Loss:** _____ **Fatigue:** _____ **Headaches:** _____ **Sinus Congestion:** _____

Ear/Balance problems: _____ **Cough:** _____**Chest pain:** _____ **Shortness of Breath:**_____

Abdominal pain: _____ **Vomiting:** _____ **Difficulty Eating:** _____ **Nausea:** _____

Arthritis: _____ **Rashes:** _____ **Weakness:**_____ **Depression or Psychological problems:**_____

Confusion: _____ **Hormonal Problems:** _____ **Bleeding or clotting problems:** _____

MEDICATION ALLERGIES:_____

_____

FAMILY HISTORY OF EYE PROBLEMS?_____

RACE:_____ **ETHNICITY:** _____ **PREFERRED LANGUAGE:**_____

REV 4/14