Broadway Vision Services

59 Broadway, Newark, NJ 07104
Phone 973-268-2565 Fax 973-484-3868

Medical and Vision History

Please complete this form before your visit. Your answers help the doctor care for your eyes and are kept private.

Patient information

Patient's full name _____ Date of birth _____ Today's date _____

Phone _____ Email _____ Primary care doctor _____

Your visit

Main reason for today's visit _____ Date of last eye exam _____

What do you wear now? ☐ Glasses ☐ Contact lenses ☐ Reading glasses ☐ Nothing

If you wear contacts: type or brand _____ Hours worn per day _____

Do you have any of these now?

- ☐ Blurry vision, far away
- ☐ Blurry vision, up close
- ☐ Double vision
- ☐ Eye pain
- ☐ Red eyes
- ☐ Itchy or watery eyes
- ☐ Dry or burning eyes
- ☐ Light sensitivity
- ☐ Floaters or flashes of light
- ☐ Headaches
- ☐ Eye strain with screens
- ☐ Trouble seeing at night

Eye history

You	Family		You	Family	
☐	☐	Glaucoma	☐	☐	Cataracts
☐	☐	Macular degeneration	☐	☐	Diabetic eye disease
☐	☐	Retinal detachment	☐	☐	Lazy eye (amblyopia)
☐	☐	Crossed or turned eye	☐	☐	Keratoconus
☐	☐	Eye injury	☐	☐	Blindness

Eye surgery or laser treatment (type and year)

_____

Medical history

Check any you have now or have had.

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Arthritis or lupus
- ☐ Asthma or COPD
- ☐ Migraines
- ☐ Cancer
- ☐ Kidney disease
- ☐ HIV / hepatitis
- ☐ Sleep apnea
- ☐ Depression or anxiety
- ☐ Pregnant or nursing

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If diabetic: year diagnosed and last A1C

Other conditions or surgeries

Family history

☐ Diabetes ☐ High blood pressure ☐ Heart disease ☐ Stroke

Medications

Include pills, eye drops, inhalers, vitamins and supplements.

Medication	Dose	What it's for

Allergies

☐ No known allergies

Medication allergies and reaction

Other allergies (latex, foods, seasonal)

Lifestyle

Occupation

Hours on screens per day

Do you drive? ☐ Yes ☐ No

Do you smoke or vape? ☐ Yes ☐ No

Alcohol ☐ Never ☐ Sometimes ☐ Daily

Signature

The information on this form is correct to the best of my knowledge. I will tell the office if my health or medications change.

Signature of patient (or parent/guardian)

Date

If signing for the patient, relationship

Office use: Reviewed by