



Black ink only please!

Mr / Mrs / Ms / Dr

**Patient History Form**

Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_

**Insurance Information**

Plan Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Dependent

Insured ID#: \_\_\_\_\_ Insured SS# (if different): \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

Do you have any allergies to medications: Y N If yes, explain \_\_\_\_\_

List any **medications** you take: \_\_\_\_\_

**Ocular Review of Systems:** Do YOU currently have or have YOU ever had?

Blurred Vision	Y	N	Eye Infections	Y	N
Dry Eyes	Y	N	Cataracts	Y	N
Itchy Eyes	Y	N	Glaucoma	Y	N
Eye Discharge	Y	N	Macular Degeneration	Y	N
Tearing	Y	N	Retinal Detachments	Y	N
Floating Spots	Y	N	Lazy Eye	Y	N
Flashing Lights	Y	N	Eye Surgery	Y	N

Please give details for all "yes" \_\_\_\_\_

**Contact Lens Questions:**

Are you interested in Contact Lenses?	Y	N
Have you ever worn contacts?	Y	N
Do you now wear contacts?	Y	N
What type? _____		
How long have you had this pair? _____		
Do you sleep in your contacts?	Y	N
Are you happy with your current lenses?	Y	N
Do your eyes feel irritated with contacts?	Y	N
Are you interested in trying a new lens?	Y	N
Are you interested in Laser Eye Surgery?	Y	N

**Review of Systems:** Do YOU currently have or have YOU ever had any problems in the following areas? Circle all that apply

<b>CONSTITUTIONAL</b> Fever, Weight Loss, other	<b>RESPIRATORY</b> Asthma, Emphysema, COPD, other	<b>BONES/JOINTS/MUSCLES</b> Rheumatoid Arthritis, Fibromyalgia, other
<b>INTEGUMENTARY (skin)</b> Herpes zoster/shingles, Rosacea, other	<b>CARDIOVASCULAR</b> Hypertension, Stroke, Heart Disease, other	<b>HEMOTOLOGIC/LYMPHATIC</b> Leukemia, Anemia, Bleeding, other
<b>NEUROLOGICAL</b> Headache, Migraines, Seizures, MS, other	<b>GASTROINTESTINAL</b> Crohns, Ulcer, other	<b>ALLERGIC/IMMUNOLOGIC</b> Allergies, Autoimmune Disease, other
<b>ENDOCRINE</b> Diabetes, Thyroid, other	<b>GENITOURINARY</b> Kidney, Bladder, other	<b>PSYCHIATRIC</b> Anxiety, Depression

**Family History:** Please note any family members (parents, grandparents, siblings, children) with any of these conditions

Blindness	Y	N	Who: _____	Macular Degeneration	Y	N	Who: _____
Glaucoma	Y	N	Who: _____	Retinal Detachment	Y	N	Who: _____
Cataracts	Y	N	Who: _____	High Blood Pressure	Y	N	Who: _____
Diabetes	Y	N	Who: _____	Cancer	Y	N	Who: _____