**PATIENT HEALTH HISTORY**

**TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We would like to thank the person who referred you to our office, how did you hear about us?**

Yellow Pages Insurance Google Friend/ Co-worker Family Other

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**So, we may better serve your vision needs, please complete the questions below regarding your visit today:**

**Date of Last Eye Examination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Your reason(s) for visiting our office today: (please check all applicable items)**

|  |  |  |
| --- | --- | --- |
| \_\_\_ General check up | \_\_\_ Headaches | \_\_\_ Want contact lenses |
| \_\_\_ Laser vision consultation | \_\_\_ Light sensitivity | \_\_\_ Standard soft |
| \_\_\_ Lost or broken glasses | \_\_\_ Eyes water | \_\_\_ Disposable |
| \_\_\_ Want new eyeglasses | \_\_\_ Eyes itch | \_\_\_ Tinted/ colored |
| \_\_\_ Blurred distance vision | \_\_\_ Eyes feel dry | \_\_\_ Bifocal/ Multifocal |
| \_\_\_ Blurred intermediate vision | \_\_\_ Pain in eyes | \_\_\_ Gas permeable |
| \_\_\_ Blurred near vision | \_\_\_ Flashes of lights | \_\_\_ Other |
| \_\_\_ Night vision problems | \_\_\_ Floating spots in vision |  |
| \_\_\_ Double vision | \_\_\_ Eyes feel tired |  |

**Do you work on a computer?** \_\_\_\_ Yes \_\_\_\_ No If so, how many hours a day? \_\_\_\_\_\_\_\_\_\_\_\_\_ \***Have you had any eye surgeries or laser treatments on your eyes?** \_\_\_ YES\_\_\_NO

If yes, when and what was done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* Are you pregnant or nursing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Lens Questionnaire:**

* Are you wearing contact lenses today? \_\_\_ Yes \_\_\_ No
* If yes, what type? \_\_\_ Soft \_\_\_ Rigid/ Gas Permeable
* What type of solution do you use to clean and disinfect? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* If you have worn contact lenses in the past and no longer wear them, please tell us why you quit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

* Have you ever used tobacco products? \_\_\_ Yes \_\_\_ No
* If yes, what type/amount/how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you drink alcohol? \_\_\_ Yes \_\_\_ No
* If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# \*\*\*PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE\*\*\*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FAMILY HISTORY** | **YES** | **WHO? (Blood Relative ONLY)** | |  | | | **YES** | **WHO?** |
| Arthritis |  |  | | | Blindness | |  |  |
| Diabetes |  |  | | | Crossed Eyes | |  |  |
| High Cholesterol |  |  | | | Glaucoma | |  |  |
| High Blood Pressure |  |  | | | Mac. Degeneration | |  |  |
| Cataracts |  |  | | | Retinal Disease | |  |  |
| **PERSONAL MEDICAL HISTORY**  **Date of Last Medical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Name of Medical Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone **#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you take any **MEDICATIONS**? If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ALLERGIES TO ANY MEDICATIONS?** \_\_\_\_ Yes \_\_\_\_ No  If yes, list medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What happens if given medication(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PLEASE (X) IF YOU HAVE ANY OF THESE CONDITION: IF NONE, PLEASE MARK HERE \_\_\_\_\_\_\_** | | | | | | | | |
| **GENERAL HEALTH** | | | **ENDOCRINE** | | | **SKIN** | | |
| Fever | | | Diabetes Type: I II | | | Eczema | | |
| Fatigue | | | When diagnosed: | | | Rosacea | | |
| Pregnant | | | Last HbA1c | | | Other | | |
| Breast feeding | | | Thyroid (specify): | | | **MUSCLE/ SKELETAL** | | |
| Trauma | | | Other | | | Arthritis Type: | | |
| Other | | | **GASTROINTESTINAL** | | | Fibromyalgia | | |
| **OCULAR** | | | Crohn's Disease | | | Ankylosing Spondylitis | | |
| Cataracts | | | Colitis | | | Other | | |
| Glaucoma | | | Hepatitis Type: | | | **NEUROLOGICAL** | | |
| Macular degeneration | | | Other | | | Multiple Sclerosis | | |
| Retinal condition | | | **GENITAL/ URINARY** | | | Epilepsy | | |
| Other | | | Herpes | | | Other | | |
| **ALLERGIC/IMMUNOLOGIC** | | | Other | | | **PSYCHIATRIC** | | |
| Lupus (SLE) | | | **EARS, NOSE, THROAT** | | | Bipolar | | |
| Rheumatoid Arthritis | | | Post Nasal Drip | | | Anxiety | | |
| HIV Positive | | | Sinusitis | | | Depression | | |
| Other | | | Upper Respiratory Infection | | | Schizophrenia | | |
| **CARDIOVASCULAR** | | | Other | | | Other | | |
| High Blood Pressure | | | **HEMATOLOGIC/ LYMPHATIC** | | | **RESPIRATORY** | | |
| Heart Disease | | | Anemia | | | Asthma | | |
| Cholesterol | | | Leukemia | | | Bronchitis | | |
| Vascular disease | | | Other | | | Emphysema | | |
| Other | | |  | | | Other | | |

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ UPDATED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**