**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 \_\_\_\_ NoIf 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**