

PATIENT HEALTH AND VISION HISTORY FORM

Your Name _____ Today's Date _____
(Last) (First) (M.I.)

I Prefer to be called: _____ Social Security Number _____

Occupation _____ Employed by: _____

Home Address _____ Home Email: _____

City _____ State _____ Zip _____

Home Ph. _____ Work ph. _____ Cell Ph. _____

Your Birthdate _____ Age _____ Name of Spouse/Parent _____

Students: School Now Attending _____ Grade in School: _____

Have any members of your family been here before? (*names*)

How did you first hear about our office? (*NEW PATIENTS ONLY, please be specific*)

Yellow Pages: _____ Insurance Plan: _____ Friend: (*who*) _____
Location (sign): _____ Family: _____ Other: _____

Medical History

Have you ever had an **eye** injury, disease, or surgery? Yes No

Were your eyes "crossed" as a child? Yes No

Do you now, or have you ever worn eyeglasses? Yes No

How old are your glasses? _____

Do you now, or have you ever worn Contact Lenses? Yes No
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Are you interested in being evaluated for Contact Lenses? Yes No Maybe

When was your last eye exam? _____

Are you allergic to any medications? Yes No

(*specify*) _____

Are you pregnant or nursing? Yes No

List all major illnesses or medical conditions for which you have been under care (*specify*)

List any medications and the purpose of each that you are taking or have taken in the last year including non-prescription drugs.

Do you have a family history of any of the following?

Glaucoma? Family Self No Macular Degeneration Family Self No

Cataracts? Family Self No Thyroid Disease? Family Self No

Diabetes? Family Self No High Blood Pressure? Family Self No

Do you have any of the following eye related problems? (*Circle all that apply*)

Blurred vision	Excessive redness	Flashes of light in darkness
Eye pain	Gritty feeling	Floating spots
Double vision	Itching	Glare
Dry eyes	Burning	Chronic infection
Mucous discharge	Excessive Tearing	Loss of vision

Review of Systems: *Have you ever had or do you now have any of the following?*

- Allergic / immunologic problems (allergies, immune disorders, _____) Yes No
Ear / Nose / Throat problems (hearing loss, sinus problems, dry mouth, _____) Yes No
Endocrine (thyroid, diabetes, _____) Yes No
Constitutional (Chronic fever, unexpected weight loss / gain, _____) Yes No
Cardiovascular problems (hypertension, irregular heartbeat, _____) Yes No
Musculoskeletal problems (arthritis, other _____) Yes No
Neurological problems (headaches, seizures, stroke, _____) Yes No
Psychiatric problems (depression, anxiety, _____) Yes No
Respiratory problems (asthma, TB, emphysema, _____) Yes No
Skin problems (acne, melanoma, rashes, _____) Yes No

Social History & Life Style:

- Do you Smoke? Yes No
Do you Drive? Yes No
Are you bothered by the glare of lights when you drive? Yes No
Do you have difficulty seeing to drive at night? Yes No
Do you currently wear prescription lenses for near/reading? Yes No
Do you feel that your eyes are very sensitive to sun light? Yes No
Do you work or play at a computer? Yes No
Do you enjoy spending time outdoors? Yes No
Are you interested in learning more about eliminating glasses or contact lenses through Laser vision correction? Yes No
Is there any activity that causes unusual eyestrain on your eyes? (*list*) Yes No

When do you wear your visual correction if any _____

Areas To Improve With New Glasses

(*Check all that apply*)

- Marks on nose
 Soreness on ears or nose
 Too heavy
 Sensitive to car lights
 Slip Down
 Corrosion
 Lenses resting on cheeks
 Tint too Dark

Sports and Activities

- Tennis, Racquetball, etc
 Soccer, Contact Sports
 Swimming
 Skiing, Snow Sports
 Golf
 Running, Walking
 Hunting, Shooting
 Boating, Fishing, Camping
 Aerobics, Dancing
 Other

Fashion Eyewear Needs

Are you interested in eyewear for any of the following?

- Prescription Sun wear
 Evening wear
 Sports wear
 Business wear

Hobbies

- Needlework
 Gardening
 Home workshop
 Stamp / coin collecting
 Music
 Card playing
 Reading
 Cooking
 Home Computer
 Dining Out
 Other

THANK YOU!

We want to thank you for selecting our office and for trusting us with your eye health and precious vision. We will strive to provide you with the best vision care available. Your eye health and optimal vision performance are our primary concern.