Patient History Form

Patient Name: _____ **Date of birth:** ____ / ____ / ____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Social Security Number: _____ **Occupation/Employer:** _____

Preferred method of contact:

- Email: _____
- Cell Phone: _____
- Phone (work or home): _____

Date of Last Eye Exam: ____ / ____ / ____ Name of Eye Doctor/Clinic: _____

Date of last Medical Exam: ____ / ____ / ____ Name of Doctor/Clinic: _____

How did you hear about us? (*Please circle*) Insurance Family Internet Other: _____

Do you wear glasses? Yes / No **Do you wear them:** all the time / Sometimes / Work only / Reading only / Driving only

How old are your present glasses: _____ **Do you wear sunglasses?** Yes / No

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Do you wear contacts? Yes / No **Type/Brand:** _____ **Solution used:** _____

Wearing schedule: Daily / Overnight **Replacement Schedule:** Daily / 2 week / Monthly / Yearly varied

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Have you ever had any eye injuries? Yes / No Describe: _____

Have you ever had any eye surgeries? Yes / No Describe: _____

Do you use any eye medication? Yes / No Describe: _____

Have you ever been diagnosed with any of the following?

Cataracts:	Yes / No	Retinal Detachment:	Yes / No
Glaucoma:	Yes / No	Crossed or Lazy Eye:	Yes / No
Macular Degeneration:	Yes / No	Eye turn or strabismus:	Yes / No
Dry Eyes:	Yes / No	Blindness or loss of vision:	Yes / No

What is your primary vision concern today? _____

Please list any activities you have difficulty doing because of your eyes or eyesight: _____

_____

*****Please turn over and complete the other side*****

Personal Medical History: *Please check if any of the following applies to you past or present and list all medications taken below. If you have none of these conditions please check NONE.*

Cardiovascular: ___ High Blood Pressure ___ Heart Disease ___ Vascular Disease ___ Stroke ___ Cancer ___ Other: _____ ___ None	**Constitutional:** ___Cancer: _____ ___ Fatigue Syndrome ___ Developmental disability ___ Other: _____ ___ None	**Psychiatric:** ___ ADHD ___ Depression ___ Schizophrenia ___ Anxiety ___ Bipolar Disorder
Neurological: ___ Multiple Sclerosis ___ Epilepsy/ Seizure ___ Cerebral Palsy ___ Tumor ___ Migraines ___ Other: _____ ___ None	**Musculoskeletal:** ___ Arthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Osteoarthritis ___ Osteoporosis ___ Other: _____ ___ None	**Integumentary:** ___ Eczema ___Rosacea ___ Shingles ___ Psoriasis ___ Other: _____ ___ None
Hematological: ___ Anemia ___ Leukemia ___ Ulcer ___ Hypercholesterolemia ___ Other: _____ ___ None	**Gastrointestinal:** ___ Cohn's Disease ___ Colitis ___ Ulcer ___ Acid Reflux ___ Other: _____ ___ None	**Ear/Nose/Throat:** ___ Hearing Loss ___ Sinusitis ___ Dry Mouth ___ Other: _____ ___ None
Endocrine: ___ Type 2 Diabetes ___ Type 1 Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other: _____ ___ None	**Respiratory:** ___Asthma ___ Bronchitis ___Emphysema ___ COPD ___ Sleep Apnea ___ Other: _____ ___ None	**Allergies: (Please List)** **___ None** Drug/Medication: Environmental: **Tobacco Use:** Current / Past / Never

Please list any medications you are currently taking or ask our staff to make a copy of your medication list. Include all medications, vitamins, herbs, supplements, and over the counter medications

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Family History: *Has anyone in your immediate family (grandparents, parents, siblings and children) been diagnosed with:*

Disease/Condition		**Relationship**			**Relationship**
Lupus	Yes / No	_____	Blindness	Yes / No	_____
High Blood Pressure	Yes / No	_____	Cataracts	Yes / No	_____
Diabetes	Yes / No	_____	Glaucoma	Yes / No	_____
Heart Disease	Yes / No	_____	Crossed Eyes	Yes / No	_____
Thyroid Disease	Yes / No	_____	Macular Degeneration	Yes / No	_____
Cancer	Yes / No	_____	Retinal Detachment	Yes / No	_____

Patient signature: _____ Date: _____