PATIENT HEALTH AND VISION HISTORY FORM

Your Name_____ Today's Date_____
(Last) (First) (M.I.)
I Prefer to be called:_____

Home Address_____

City _____ State_____ Zip_____

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

Your Birthdate_____ Social Security Number _____ Home Email: _____

Employment status: _____ Occupation:_____ Preferred Language:_____

Marital Status: ❑Married ❑Single ❑Other Ethnicity: ❑Hispanic or Latino ❑Not Hispanic Latino
Race: ❑American Indian or Alaskan ❑Asian ❑Black or African American
❑Native Hawaiian or Other Pacific Islander ❑White

How did you first hear about our office? *(NEW PATIENTS ONLY, please be specific)*
Internet: *(where)*_____ Insurance Plan:_____ Friend: *(who)*_____
Location (sign):_____ Family:_____ Other:_____
Have any members of your family been here before? *(names)*
_____

Medical History

Have you ever had an **eye** injury, disease, or surgery?	❑Yes ❑No
Do you Smoke?	❑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
	❑hard ❑soft
Are you interested in being evaluated for Contact Lenses?	❑Yes ❑No ❑Maybe
When was your last eye exam?_____	
Are you pregnant or nursing?	❑Yes ❑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

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

_____
Are you allergic to any medications? ❑Yes ❑No
*(specify)*_____
List all major illnesses or medical conditions for which you have been under care *(specify)*

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

Glaucoma	❑Parent	❑Sibling	❑No	Diabetes	❑Parent	❑Sibling	❑No
Cataracts	❑Parent	❑Sibling	❑No	High Cholesterol	❑Parent	❑Sibling	❑No
Macular Degeneration	❑Parent	❑Sibling	❑No	High Blood Pressure	❑Parent	❑Sibling	❑No

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

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

Social History & Life Style:

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 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 or 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.