

Mr / Mrs / Ms / Dr

Patient History Form

Today's Date ___ / ___ / ___

Patient Name: _____ Date of Birth ___ / ___ / ___

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

Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Occupation: _____ Employer: _____ Last Eye Exam: _____

Eyes ever been dilated: Yes (~ Year _____) No

Email: _____ Referred by/Heard about us from: _____

Insurance Information

Name of **VISION** Plan: _____ Name of **MEDICAL** Plan: _____

Policy Holder's Name: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's Date of Birth: _____

Relationship to Insured: Self Spouse Dependent Relationship to Insured: Self Spouse Dependent

Policy Holder's ID or SS#: _____ Policy Holder's ID or SS#: _____

Medical Conditions/Review of Systems: Do YOU currently have or have YOU ever had (if so, when?) any diagnoses in the following areas?

CIRCLE all that apply:

CONSTITUTIONAL:

Developmental Disabilities, Cancer, Fatigue, _____

ENT (Ears, Nose, Throat):

Hearing loss, sinusitis, dry mouth, laryngitis, _____

NEUROLOGICAL:

MS, Epilepsy, CP, Tumor, Stroke/CVA, Migraine, Autism, _____

PSYCHIATRIC:

Depression, ADD/ADHD, Anxiety, Bipolar, _____

CARDIOVASCULAR:

Hypertension, Stroke, Heart Disease, Vascular Disease, CHF, _____

RESPIRATORY:

Cigarette smoker, Asthma, COPD, Sleep apnea, _____

other/add'l info

GASTROINTESTINAL/GENITOURINARY:

Crohn's, Colitis, Ulcer, Acid Reflux, Celiac, _____

Kidney disease, Prostate, STD, currently Pregnant/Nursing _____

MUSCULOSKELETAL:

Osteoarthritis, Fibromyalgia, MD, AS, Osteoporosis, Gout, _____

INTEGUMENTARY (skin):

Eczema, Rosacea, Herpes zoster/shingles, Herpes Simplex/Cold Sores

ENDOCRINE:

Type 2 Diabetes, Type 1 Diabetes, Thyroid, Hormonal, _____

HEMOTOLOGIC/LYMPHATIC:

Anemia, Ulcer, High Cholesterol, Other _____

ALLERGIC/IMMUNE:

Environmental Allergies, Rheumatoid Arthritis, Lupus, Sjogren's, _____

***PRIMARY CARE DOCTOR:**

Name/Address/Clinic Name: _____

LIST ANY MEDICATIONS (AND DOSAGES) you take (include over-the-counter medicine, **eye drops**, vitamins and supplements):

Do you have any allergies to medications: Y N If yes, list/explain _____

Ocular/Eye/Vision Review of Systems:

Do YOU currently have?

Blurred Vision Y N
Dry Eyes Y N
Itchy Eyes Y N
Eye Discharge Y N
Tearing Y N
Floating Spots Y N
Flashing Lights Y N

Have YOU ever had?

Eye Infection(s) Y N
Glaucoma (or suspect) Y N
Cataracts Y N
Macular Degeneration Y N
Retinal Detachment Y N
Lazy Eye Y N
Eye Surgery Y N
Dry Eye Y N

Details: _____

Contact Lens Questions:

Are you interested in contact lenses? Y N
Have you ever worn contacts? Y N
Do you now wear contacts? Y N
What type? _____
How long have you had this pair? _____
Do you sleep in your contacts? Y N
Are you happy with your current lenses? Y N
Feel dry/irritated with your current brand? Y N
Are you interested in trying a new lens? Y N
Are you interested in Laser Eye Surgery? Y N

Family History: Please note any **immediate family members (parents, siblings, children)** with any of these conditions:

Cancer Y N Who: _____ Cataracts Y N Who: _____
Diabetes Y N Who: _____ Type 1 or 2 Macular Degeneration Y N Who: _____
Hypertension Y N Who: _____ Glaucoma Y N Who: _____
Thyroid Y N Who: _____ Hyper or Hypo Blindness Y N Who/Cause: _____