

## PATIENT HEALTH HISTORY

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone(home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_  
Patient's social security# \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex M F  
How did you hear about our office? \_\_\_\_\_

**Reason for today's visit** \_\_\_\_\_

### EYE HISTORY

Date of last eye exam \_\_\_\_\_ Name of eye doctor \_\_\_\_\_  
Do you currently wear eyeglasses? Y N When? \_\_\_\_\_  
Do you currently wear contact lenses? Y N Type? Soft Hard Toric Bifocal Monovision  
How often do you replace your contacts? \_\_\_\_\_ Disinfection type: \_\_\_\_\_  
Have you had any eye surgery? Y N Type? \_\_\_\_\_ When? \_\_\_\_\_  
Have you had any eye injury? Y N Describe? \_\_\_\_\_ When? \_\_\_\_\_  
Do you have any eye diseases? Y N Kind? \_\_\_\_\_

#### **Do you currently have...**

|                                 |     |                                |     |
|---------------------------------|-----|--------------------------------|-----|
| Blurred distance vision?        | Y N | Floating dark spots in eye(s)? | Y N |
| Blurred near vision?            | Y N | Flashes of light in eye(s)?    | Y N |
| Burning, itchy, or watery eyes? | Y N | Light sensitivity/glare?       | Y N |
| Red eyes?                       | Y N | Frequent headaches?            | Y N |
| Sandy or gritty sensation?      | Y N | Double vision?                 | Y N |
| Turned eye or lazy eye?         | Y N | Eye pain?                      | Y N |

Does anyone in your family have any eye diseases ( ex. Glaucoma, cataracts, macular degeneration, retinal detachment)

\_\_\_\_\_

### MEDICAL HISTORY

Date of last medical exam \_\_\_\_\_ Doctor's name \_\_\_\_\_  
Have you had any surgeries? Y N Kind? \_\_\_\_\_ When? \_\_\_\_\_  
Do you have allergies to medications? Y N Type? \_\_\_\_\_  
Are you pregnant? Y N N/A \_\_\_\_\_ Number of children \_\_\_\_\_

#### **Do you have...**

|                       |     |                      |     |                              |     |
|-----------------------|-----|----------------------|-----|------------------------------|-----|
| Hypertension          | Y N | Diabetes             | Y N | Heart disease                | Y N |
| Thyroid dysfunction   | Y N | Asthma               | Y N | High Cholesterol             | Y N |
| Vascular disease      | Y N | Rheumatoid arthritis | Y N | Kidney disease               | Y N |
| Sinus trouble         | Y N | Seasonal allergies   | Y N | Emphysema                    | Y N |
| Depression or anxiety | Y N | Lupus                | Y N | Migraines                    | Y N |
| Anemia                | Y N | Leukemia             | Y N | Eczema                       | Y N |
| Rosacea               | Y N | Psoriasis            | Y N | Multiple Sclerosis           | Y N |
| Colitis               | Y N | Ulcer                | Y N | Sexually transmitted disease | Y N |
| Cancer                | Y N | Epilepsy             | Y N | Developmental disability     | Y N |
| Chronic fever         | Y N | AIDS or HIV+         | Y N | Sudden weight gain or loss   | Y N |

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Does anyone in your family have a history of medical problems as listed above? Y N  
Specify \_\_\_\_\_

**MEDICATIONS**

List **all** medications you are currently taking, including eye drops: \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

Current occupation: \_\_\_\_\_  
Hobbies/special interests \_\_\_\_\_

Marital Status:      Single      Married      Separated      Divorce      Widowed  
Living arrangements ( with spouse, alone, with children): \_\_\_\_\_

Do you drive? Y N  
Do you have difficulty when driving? Y N  
Do you have problems with night vision? Y N

Do you use a computer at home or work? Y N      How many hours? \_\_\_\_\_

Do you drink alcohol?      Never      Rarely      Moderate      Daily  
Do you smoke? Never      Previously, but not in the past \_\_\_\_\_ year(s)      Current packs/day: \_\_\_\_\_  
Have you ever had a blood transfusion? Y N

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of patient(or guardian, if minor) \_\_\_\_\_ Date \_\_\_\_\_

***Physician's review***

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_