

Please complete the "Patient Health History" on page 2 – thanks!

Patient Health History

Today's Date _____

(please print)

Please complete this form in full to the best of your knowledge.

If you have any questions or concerns, please do not hesitate to ask for assistance – we will be happy to help.

Patient Name _____ Birth Date: _____

Reason for Today's Visit: _____

What was the date of your last **Eye Exam**? _____ Eye Doctor's Name _____

What was the date of your last **Medical Exam**? _____ Medical Doctor's Name _____

Do you wear glasses? Yes No If yes, how old is your present pair of glasses? _____

If yes, when do you wear your glasses? All the time Computer work Reading/near work Distance only

Do you wear contacts? Yes No If yes, what type of contact lenses do you wear? (check all that apply)

Soft Disposable Extended wear Astigmatic Bifocal Rigid Gas Permeable Other

Are they comfortable? Yes No Describe any problems you have with your contacts

Are you interested in LASIK or other types of refractive surgery? Yes No Possibly Already had LASIK
_____ (yr.)

Please check if you are experiencing any of the following **eye or vision problems**:

Blurred vision - distance	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Blurred vision - near	<input type="checkbox"/>
Itching eyes	<input type="checkbox"/>	Color vision, poor	<input type="checkbox"/>	Light sensitive	<input type="checkbox"/>
Crossed eyes	<input type="checkbox"/>	Loss of vision	<input type="checkbox"/>	Discharge from eyes	<input type="checkbox"/>
Night vision, poor	<input type="checkbox"/>	Dizzy spells	<input type="checkbox"/>	Red eyes	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	Seeing halos	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>
Seeing flashes or floaters	<input type="checkbox"/>	Eye infection	<input type="checkbox"/>	Temporary vision loss	<input type="checkbox"/>
Eye injury	<input type="checkbox"/>	Twitching eyelid	<input type="checkbox"/>	Eye strain	<input type="checkbox"/>
Vision poor	<input type="checkbox"/>	Fainting or blackouts	<input type="checkbox"/>	Watering eyes	<input type="checkbox"/>

Please check "Patient" or "Family Member" to indicate if you or a blood relative has ever had any of the following **medical conditions**, and please indicate which family member has had the condition (mom, dad, brother, sister, etc.):

	Patient	Family Member		Patient	Family Member
1. AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/> _____	17. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/> _____
2. Arthritis	<input type="checkbox"/>	<input type="checkbox"/> _____	18. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/> _____
3. Asthma	<input type="checkbox"/>	<input type="checkbox"/> _____	19. Lazy eye	<input type="checkbox"/>	<input type="checkbox"/> _____
4. Allergies, Seasonal	<input type="checkbox"/>	<input type="checkbox"/> _____	20. Lupus	<input type="checkbox"/>	<input type="checkbox"/> _____
5. Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/> _____	21. Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/> _____
6. Blindness	<input type="checkbox"/>	<input type="checkbox"/> _____	22. Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/> _____
7. Cancer	<input type="checkbox"/>	<input type="checkbox"/> _____	23. Poor color vision	<input type="checkbox"/>	<input type="checkbox"/> _____
8. Cataracts	<input type="checkbox"/>	<input type="checkbox"/> _____	24. Retinal disease/detachment	<input type="checkbox"/>	<input type="checkbox"/> _____
9. Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/> _____	25. Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/> _____
10. Diabetes	<input type="checkbox"/>	<input type="checkbox"/> _____	26. Shingles	<input type="checkbox"/>	<input type="checkbox"/> _____
11. Emphysema	<input type="checkbox"/>	<input type="checkbox"/> _____	27. Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/> _____
12. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> _____	28. Stroke	<input type="checkbox"/>	<input type="checkbox"/> _____
13. Eye surgery	<input type="checkbox"/>	<input type="checkbox"/> _____	29. Thyroid conditions	<input type="checkbox"/>	<input type="checkbox"/> _____
14. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/> _____	30. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/> _____
15. Heart disease	<input type="checkbox"/>	<input type="checkbox"/> _____	31. Turned eye (in or out)	<input type="checkbox"/>	<input type="checkbox"/> _____
16. Hepatitis (Type____)	<input type="checkbox"/>	<input type="checkbox"/> _____	32. Other _____	<input type="checkbox"/>	<input type="checkbox"/> _____

Are you pregnant? Yes / No Are you nursing? Yes / No Smoker? Yes / No Alcohol use? Yes / No

Please list all major injuries, surgeries (including any eye surgeries), and/or hospitalizations you have had:

Medical Allergies

Please list all of your allergies to any medications or other substances:

Current Medications

Please list all medications you are currently taking, including over-the-counter medications and eye drops:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered, and I understand that providing incorrect information can be dangerous to my health. I also understand that this information will be held in the strictest of

confidence and that it is my responsibility to inform the doctor and/or staff of any changes in my medical status. By signing this form, I give consent for the doctor to examine, diagnose, and initiate treatment as deemed appropriate for myself.

Signature of Patient or Guardian

Date