

**PATIENT HISTORY AND INFORMATION DATE**

Name Date of Birth / /

 LAST FIRST MI NICKNAME

Address Sex □ Male □ Female Age

 STREET NAME

 Social Security Number

 CITY STATE ZIPCODE

Home Telephone Cell Phone

Date of Last Eye Exam / / . Email Address

Occupation Employer

Primary Care Physician Phone Number

Medical Insurance Carrier PPO / HMO

**GLASSES HISTORY CONTACT LENS HISTORY**

Do you wear glasses? □ Yes □ No Do you wear contacts □ Yes □ No

a) For: □ Near □ Distance □ Both

b) □ Single Vision □ Bifocals a) □ Full Time □ Part Time □ Rarely

□ Progressive □ Trifocals b) Type of Contacts?

c) Any Problems? □ Daily Wear □ Extended Wear

d) Do you wear sunglasses? □ Yes □ No □ Soft Toric □ Gas Permeable

e) Are your sunglasses prescription? □ Yes □ No c) What cleaning solution do you use? .

 d) If you do not wear contacts, are you interested in trying them?

 □ Yes □ No

**SOCIAL HISTORY**

Do you engage in regular exercise? □ Yes □ No

Do you drink alcohol? □ Yes □ No

Do you smoke? □ Yes □ No

Which of the following do you do regularly?

□ Night Driving □ Work Outdoors

□ Commute 20+ minutes by car □ Work with small objects

□ Work under fluorescent light □ Read for long periods

□ Work on a computer □ Travel on airplanes

□ Watch television 3+ hours per day □ Frequently alternate between indoors and outdoors

□ Work at a desk □ Other

□ List any sports or hobbies you participate in

**OCULAR SURFACE DISEASE HISTORY**

Do your eyes ever feel or do you experience: Never Slight Moderate Severe

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Gritty or sandy sensation? |  |  |  |  |
| Pain or soreness? |  |  |  |  |
| Fluctuating vision? |  |  |  |  |
| Occasional tearing? |  |  |  |  |
| Blurred vision while reading or computer use? |  |  |  |  |
| Discomfort in windy conditions? |  |  |  |  |
| Discomfort in Heating/Air Conditioned areas? |  |  |  |  |

**FAMILY MEDICAL HISTORY**

**EYE DISEASES**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No | Who |   | Yes | No | Who |
| Amblyopia (Lazy Eye) |  |  |  | Color Blindness |  |  |  |
| Eye Tumor |  |  |  | Glaucoma |  |  |  |
| Blindness |  |  |  | Macular Degeneration |  |  |  |
| Cataract(s) |  |  |  | Retinal Detachment |  |  |  |

**SYSTEMIC DISEASES**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No | Who |  | Yes | No | Who |
| Arthritis |  |  |  | High Cholesterol |  |  |  |
| Cancer |  |  |  | Stroke |  |  |  |
| Diabetes |  |  |  | Kidney Disease |  |  |  |
| Heart Disease |  |  |  | Lupus |  |  |  |
| High Blood Pressure |  |  |  | Thyroid Disease |  |  |  |

**PATIENT MEDICAL HISTORY**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No |  | Yes | No |  | Yes | No |
| Allergies (seasonal) |  |  | Glaucoma |  |  | Computer Eye Strain |  |  |
| Excessive Weight Changes |  |  | Cataract(s) |  |  | Strabismus (Crossed Eyes) |  |  |
| Ear, Nose, Throat  |  |  | Macular Degeneration |  |  | Blurred Vision at Distance |  |  |
| High Blood Pressure |  |  | Retinal Detachment |  |  | Blurred Vision at Near |  |  |
| Asthma/Breathing Problems |  |  | Color Blindness |  |  | Distorted Vision (halos) |  |  |
| Stomach Problems |  |  | Glare/Light Sensitivity |  |  | Double Vision |  |  |
| Arthritis/Osteoporosis |  |  | Tired Eyes |  |  | Floaters or Spots |  |  |
| Skin Problems |  |  | Amblyopia |  |  | Fluctuating Vision |  |  |
| MS/Seizures |  |  | Burning Eyes |  |  | Loss of Vision |  |  |
| Anxiety/Depression |  |  | Dryness |  |  | Loss of Side Vision |  |  |
| Kidney Problems |  |  | Excess Tearing/Watering |  |  |
| Diabetes |  |  | Eye Pain/Soreness |  |  |
| Thyroid Problems |  |  | Itching |  |  |
| Anemia/Blood Disorders |  |  | Mucous Discharge |  |  |
| Lyme Disease |  |  | Sandy or Gritty Feeling |  |  |
| HIV/Herpes |  |  | Ptosis (drooping eyelid) |  |  |
| Cancer (What type?): |  |  | Redness |  |  |

Eye injuries, infections or surgeries (including LASIK)

Any other surgeries

Medications that cause reactions or sensitivities

Specific Allergies

Current Medications (including vitamins & herbal supplements)

Thank you for taking the time to help our office personalize your eye care. Your answers will help guide our doctors and staff to your specific needs. We look forward to seeing you for your examination and please feel free to let us know if you have any other needs or concerns we have not addressed.

*This form was reviewed and electronically signed in the Electronic Health Records (EHR) system.*