Patient Health and History

About Your Eyes

Name_____ **Date**_____
What specific problem with your eyes brought you into our office? Please explain: _____

_____

Are you being seen in our office for a work related injury? If so, please describe.

_____

Do you frequently experience or have: (please check all that apply)

( ) Blurred vision at near	( ) Dry eyes	( ) Seeing rings around lights
( ) Blurred vision distance	( ) Gritty, sandy eyes	( ) Color vision difficulties
( ) Distorted vision	( ) Discharge from eyes	( ) Distance judgment problem
( ) Tired eyes	( ) Dizziness	( ) School difficulties
( ) Eye pain	( ) Headaches	( ) Losing place while reading
( ) Red eyes	( ) Drawing, pulling	( ) Night vision problems
( ) Watery eyes	( ) Excessive blinking	( ) Extreme light sensitivity
( ) Itchy eyes	( ) Excessive squinting	( ) Double vision
( ) Burning eyes	( ) Seeing spots or dots	( ) Other_____

Have you been prescribed glasses? ( ) Yes ( ) No If yes, how often do you wear them?_____
Last eye exam:_____Occupation:_____
Do you wear contact lenses? ( ) Yes ( ) No If yes, what type? _____
Type of contact lens solution:_____
Do you sleep in your contacts? ( ) Yes ( ) No If yes, how many nights per week?_____
Do you spend time at a computer? ( ) Yes ( ) No If yes, how many hours a day?_____
Do you currently use any drops or medications for your eyes? If so, please list:_____

_____

Eye Disease: Do you **now**, or have you **ever** had, any of the following eye complications?

( ) Cataract	( ) Glaucoma	( ) Eye injury:_____
( ) Diabetic Retinopathy	( ) Amblyopia/ Lazy eye	( ) Eye surgery:_____
( ) Macular Degeneration	( ) Turned or crossed eyes	( ) Other:_____

Family Eye History: Have your **parents, siblings, or children** had any of the following eye diseases? Please note Maternal or Paternal side of the family.

( ) Blindness:_____( ) Glaucoma:_____
( ) Cataract:_____( ) Macular Degeneration:_____
( ) Amblyopia/ Lazy eye:_____( ) Detached Retina:_____
( ) Turned or crossed eye:_____( ) Other:_____

About Your General Health

Family Physician/Clinic: _____ Last Exam:_____
Height: _____ Weight:_____ Blood Pressure:_____
Do you currently have any of the following problems?

( ) High blood pressure	( ) Stroke / Neurological disease	( ) Lung disease
( ) Heart disease	( ) Psychiatric problems	( ) Emphysema
( ) ADD/ADHD	( ) Ear/ Mouth/ Nose/ Throat	( ) Asthma
( ) Thyroid disease	( ) Irregular Heart Beat	( ) Sinus disease
( ) Kidney/ Urinary/ Genital	( ) Stomach/ Intestinal	( ) Joint/ Muscle Pain
( ) Blood disorders/ Bleeding	( ) Fever/ Weight loss	( ) Reactions to anesthetics
( ) Seasonal allergies	( ) Skin	( ) HIV/ AIDS
( ) Migraines	( ) Lupus	( ) Sjogren's Syndrome

( ) Cancer: Type:_____
( ) Diabetes: Onset:_____ Blood Sugar levels:_____ A1c:_____

Do you smoke? ( ) Yes ( ) No If yes, how many packs a day?___ For how many years?____
Do you use a Vaper ( ) Yes ( ) No
If you smoked in the past, how long ago did you quit?_____
Do you use smokeless tobacco? ( ) Yes ( ) No
Alcohol use: ( ) None ( ) Social use only ( ) 1-2 drinks daily ( ) 3 or more drinks daily

Medications: Please list all medicines you take, including aspirin (list eye medications above):

_____
_____
_____
_____
_____

Allergies: Please list all allergies to medicines that you have and the reactions they cause:

_____

Illnesses/ Injuries: Please list all past major illnesses or injuries you have had:

_____
_____

Surgeries: Please list all past surgeries and dates (list eye surgeries above)

Surgeries	**Date of Surgery**

Family History: Please list all medical conditions that affect your parents, siblings, or children:

Relation	**Medical Condition**

Have any of your family members been seen in our clinic? If so, please list:

_____

_____ _____ _____ _____

Patient signature Date Physician signature Date