Patient Health and History

About Your Eyes

Name:_____ **Date:**_____

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

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

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

( ) Blurred vision at near	( ) Dry eyes	( ) Color vision difficulties
( ) Blurred vision at distance	( ) Gritty / Sandy eyes	( ) School difficulties
( ) Tired eyes	( ) Discharge from eyes	( ) Distance judgement problem
( ) Eye pain / Pressure	( ) Dizziness	( ) Losing place while reading
( ) Red eyes	( ) Headaches	( ) Night vision problems
( ) Watery eyes	( ) Excessive blinking	( ) Extreme light sensitivity
( ) Itchy eyes	( ) Excessive squinting	( ) Other_____
( ) Burning eyes	( ) Seeing spots or dots	
( ) Allergy eyes	( ) Double vision	

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:_____

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 / Emphysema
( ) Heart disease	( ) Psychiatric problems	( ) Asthma
( ) ADD / ADHD	( ) Ear / Mouth / Nose / Throat	( ) Sinus issues
( ) Thyroid disease	( ) Irregular Heart Beat	( ) Skin issues
( ) Kidney / Urinary / Genital	( ) Stomach / Intestinal	( ) Joint / Muscle pain
( ) Blood disorders / Bleeding	( ) Fever	( ) Reactions to anesthetics
( ) Seasonal Allergies	( ) Weight Loss	( ) HIV / AIDS
( ) Migraines	( ) Sjogren's Syndrome	( ) Other

( ) Cancer: Type:_____ Diagnosis Year:_____ Remission: ( ) Yes ( ) No
( ) Diabetes: Onset:_____ Blood Sugar Levels:_____ A1c:_____
Are you pregnant? ( ) Yes ( ) No Are you nursing? ( ) Yes ( ) No

Do you smoke / vape? ( ) Yes ( ) No If yes, how much per day?_____ How many years?_____
Alcohol use: ( ) None ( ) Social use only ( ) 1-2 drinks per day ( ) 3 or more drinks per day

Medications: Please list all medicines you take, including aspirin and supplements:

_____
_____
_____
_____

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:

Surgeries	**Date of Surgery**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family 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:_____
( ) Cataracts: _____ ( ) Macular Degeneration: _____
( ) Amblyopia / Lazy eye:_____ ( ) Detached Retina:_____
( ) Turned or crossed eye:_____ ( ) Other:_____

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

Medical Condition	**Relation**
( ) Diabetes: Type I / Type II_____	_____
( ) High Blood Pressure:_____	_____
( ) High Cholesterol:_____	_____
( ) Thyroid issues:_____	_____
( ) Cancer: _____	_____
( ) Heart disease:_____	_____
( ) Other:_____	_____

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

_____