Patient Information and Health History

Name: _____ **Today's Date:** _____

Address: _____ **Home Phone:** _____

City: _____ **Zip:** _____ **Cell Phone:** _____

Texting ok? ( ) Yes ( ) No

EMAIL: _____

Social Security #: _____/_____/_____ ***(Will never be given out)*** **Date of Birth:** _____

Medical Doctors name: _____

Pharmacy: _____

Last Eye Doctor: _____ **Exam Date:** _____

Employer /Occupation: _____ **Work Phone:** _____

Medical History

Do you have any medication allergies? ( ) YES or ( ) NO If yes, please list them below:

_____

_____

List ALL medications you take *(including over the counter and non-prescription drugs):*

_____

_____

_____

_____

List any MAJOR surgeries and/or hospitalizations you may have had INCLUDING eye surgeries:

_____

_____

Your Personal Medical History

Do you currently have or ever had any of the following problems: (Circle all that apply)

EAR, NOSE, MOUTH, THROAT
- Seasonal Allergies
- Sinus Congestion
- Chronic Cough
- Dry Throat/ Mouth

CARDIOVASCULAR
- Heart Pain
- High Blood Pressure
- Vascular Disease

ENDOCRINE
- Diabetes
- Thyroid
- Elevated Cholesterol

GASTROINTESTINAL
- Acid Reflux
- Gastritis

GENITOURINARY
- Kidney
- Bladder

LYMPHATIC /HEMATOLOGICAL
- Anemia
- Bleeding Disorders

RESPIRATORY
- Asthma
- Chronic Bronchitis
- Emphysema

MUSCLESKELETON
- Arthritis
- Lupus
- Joint Pain/Muscle Pain

NEUROLOGICAL
- Headaches
- Migraines
- Seizures

PHYCHIATRIC
- Anxiety
- Depression
- Bipolar

Please list any other medical conditions that apply if not listed above:

_____

_____

_____

_____

_____

**********PLEASE TURN THIS FORM OVER AND COMPLETE BACK SIDE**********

Family History

Please note any *FAMILY* history (Parents, Grandparents, and Siblings) that have or had the following:

Blindness _____

Cataract _____

Cross Eyes_____

Glaucoma _____

Macular Degeneration _____

Retinal Detachment _____

Arthritis _____

Cancer _____

Diabetes _____

Heart Disease _____

High Blood Pressure _____

Lupus _____

Thyroid Disease _____

GENERAL:

Do you drink alcohol? ( ) Yes ( ) No If yes, amount / how long? _____

Do you smoke? ( ) Yes ( ) No If yes, amount / how long? _____

Are you pregnant and/or nursing? ( ) Yes ( ) No

Have you ever been exposed to Hepatitis, HIV, or Syphilis? ( ) Yes ( ) No

OCULAR:

Do you wear glasses? ( ) Yes ( ) No

Are you interested in contacts? ( ) Yes ( ) No

Do you wear contacts? ( ) Yes ( ) No

If yes, what type of contacts are you wearing? _____

Are you interested in Lasik eye surgery? ( ) Yes ( ) No

Vision causing problems with: **Reading/Sports/Outdoors**

What are your hobbies or interests?

Do you presently have any problems in the following areas? *If "YES", give an explanation.*

EYES:	**YES**	**NO**	
Loss or blurred vision	**( )**	**( )**	_____
Double vision	**( )**	**( )**	_____
Itching, burning, or discharge	**( )**	**( )**	_____
Redness	**( )**	**( )**	_____
Gritty feeling, dryness or tearing	**( )**	**( )**	_____
Glare/light sensitivity, or halos	**( )**	**( )**	_____
Eye Pain or soreness	**( )**	**( )**	_____
Flashes or floaters	**( )**	**( )**	_____
Chronic eye infections	**( )**	**( )**	_____

Who can we thank for referring you? _____

Patient's Signature: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____