Name

20/20 Vision Center
NEW PATIENT HISTORY FORM

What is the main reason for today's exam ? _____

When was your last eye exam ? _____ Current Occupation and Employer: _____

HEALTH HISTORY

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

(Prescription & OTC) _____

Current Eye Drops: _____

Drug Allergies: _____

Other Allergies: _____

EYE HISTORY

Glaucoma	○ Yes	○ No	Dryness	○ Yes	○ No	Strabismus (Crossed Eyes)	○ Yes	○ No
Cataract	○ Yes	○ No	Excess Tearing/Watering	○ Yes	○ No	Blurred Vision Distance	○ Yes	○ No
Retinal Detachment	○ Yes	○ No	Eye Pain or Soreness	○ Yes	○ No	Blurred Vision Near	○ Yes	○ No
Macular Degeneration	○ Yes	○ No	Foreign Body Sensation	○ Yes	○ No	Distorted Vision (halos)	○ Yes	○ No
Color Blindness	○ Yes	○ No	Infection of Eye or Lid	○ Yes	○ No	Double Vision	○ Yes	○ No
Headaches	○ Yes	○ No	Itching	○ Yes	○ No	Floaters or Spots	○ Yes	○ No
Glare/Light Sensitivity	○ Yes	○ No	Mucous Discharge	○ Yes	○ No	Fluctuating Vision	○ Yes	○ No
Tired Eyes	○ Yes	○ No	Drooping Eyelid	○ Yes	○ No	Loss of Vision	○ Yes	○ No
Amblyopia (Lazy Eye)	○ Yes	○ No	Redness	○ Yes	○ No	Loss of Side Vision	○ Yes	○ No
Burning	○ Yes	○ No	Sandy or Gritty Feeling	○ Yes	○ No			

GENERAL HEALTH CONDITIONS

Fever	○ Yes	○ No	Respiratory (Asthma)	○ Yes	○ No	Anxiety or Depression	○ Yes	○ No
Weight Loss	○ Yes	○ No	Gastrointestinal	○ Yes	○ No	Endocrine (Thyroid, Diabetes)	○ Yes	○ No
Other Symptoms	○ Yes	○ No	Kidney	○ Yes	○ No	Blood/Lymph	○ Yes	○ No
Ears, Nose, Throat	○ Yes	○ No	Muscles, Bones, Joints	○ Yes	○ No	Allergies	○ Yes	○ No
Cardiovascular (high blood pressure)	○ Yes	○ No	Skin	○ Yes	○ No	Are you?	☐ Pregnant ☐ Nursing	
			Neurological	○ Yes	○ No			

FAMILY HISTORY

Amblyopia (Lazy Eye)	○ Yes	○ No	Retinal Detachment	○ Yes	○ No	High Blood Pressure	○ Yes	○ No
Blindness	○ Yes	○ No	Strabismus (Eye Turn)	○ Yes	○ No	Kidney Disease	○ Yes	○ No
Cataract(s)	○ Yes	○ No	Arthritis	○ Yes	○ No	Lupus	○ Yes	○ No
Color Blindness	○ Yes	○ No	Cancer	○ Yes	○ No	Stroke	○ Yes	○ No
Glaucoma	○ Yes	○ No	Diabetes	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
Macular Degeneration	○ Yes	○ No	Heart Disease	○ Yes	○ No	Others	○ Yes	○ No

ADDITIONAL QUESTIONS

Do you have problems with night vision or glare ? ○ Yes ○ No

Do you wear sunglasses regularly ? ○ Yes ○ No Are they prescription sunglasses ? ○ Yes ○ No

Do you currently wear contact lenses ? ○ Yes ○ No

Contact lens brand and powers : _____

If not a current contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Any interest in LASIK ? ○ Yes ○ No

Do you drink alcohol ? how much/often : ○ No ○ Occasional ○ 1 per day ○ 2-3/day ○ 4+/day

Do you smoke ? how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Hobbies/ Interests : _____