Academy Contact Lens Clinic

Patient Health Information:

Date: ____/____/____

Last Name_____ First Name_____ M.I._____
What name do you wish to be called?_____D.O.B.____/____/____ Male / Female
Address:_____ City_____ State_____ Zip_____
Home Ph:( )_____Work Ph:( )_____Cell Ph:( ) _____
E-Mail Address:_____ Best Contact: HOME WORK CELL
Employer/ School_____ Occupation/ Grade _____
Emergency Contact:_____ Relation:_____ Phone # _____

History/ Reason for Visit:

Date of Last Medical Exam:_____/_____/_____ Clinic/ Physician:_____
Date of Last Eye Exam (if other than here):_____/_____/_____ Clinic: _____
Do you wear glasses? YES NO ALWAYS WORK ONLY READING ONLY DRIVING ONLY
Do you wear contacts? YES NO ALWAYS WEEKENDS SPORTS OTHER _____
If yes, what type? _____
Are you interested in wearing contact lenses? YES NO UNDECIDED
Are you interested in Lasik surgery? YES NO UNDECIDED
Have you had eye injuries/ surgeries? YES NO EXPLAIN:_____
Have you used eye medication? YES NO EXPLAIN: _____
Have you been diagnosed with? CATARACTS GLAUCOMA MACULAR DEGENERATION DIABETES
Do you work on a computer? YES NO HOW MANY HRS/ DAY?_____
Females: Are you pregnant or nursing? YES NO

Visual Symptoms: Circle any that apply:

Blurred Vision/ Distance	Burning Eyes	Floaters/ Spots	Headaches
Blurred Vision/ Near	Itchy Eyes	Flashes of Light	Migraines
Double Vision	Dry Eyes	Halos	Loss of Vision
Eye Strain	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infection	Watery Eyes	Poor Color Vision	Light Sensitivity
Eye Pain/ Soreness	Wandering Eye	Droopy Lid	Sandy/ Gritty Feeling
Tired Eyes	Mucus Discharge	Other:_____	

Form Review:

Date/ Initial_____ Date/ Initial_____
Date/ Initial_____ Date/ Initial_____
Date/ Initial_____ Date/ Initial_____
Date/ Initial_____ Date/ Initial_____

CONFIDENTIAL

****PLEASE TURN OVER AND COMPLETE OTHER SIDE***

Personal Medical History: Please check if any of the following applies to you.

Cardiovascular: **None**____ ____ Hypertension(high blood pressure) ____Stroke ____Heart Disease ____High Cholesterol ____ Other:	**Endocrine:** **None**____ ____ Non-Insulin Dep. Diabetes ____ Insulin Dep. Diabetes ____ Thyroid Problem ____ Hormonal Dysfunction ____ Other:	**Respiratory:** **None**____ ____ Asthma ____ Bronchitis ____Emphysema ____ COPD ____ Other:
Constitutional: **None**____ ____ Cancer (type)_____ ____ Trauma/Lg. Blood Loss ____ Developmental Disability ____ Other:	**Ocular:** **None**____ ____ Glaucoma ____Macular Degeneration ____ Detached Retina ____ Other:	**Psychiatric:** **None**____ ____ ADHD ____ Depression ____ Schizophrenia ____ Other:
Neurological: **None**____ ____ Multiple Sclerosis ____ Epilepsy ____ Cerebral Palsy ____ Tumor ____ Other:	**Musculoskeletal:** **None**____ ____ Osteoarthritis ____Fibromyalgia ____Muscular Dystrophy ____ Other:	**Immunological:** **None**____ ____ AIDS or HIV ____ Rheumatoid Arthritis ____ Lupus ____ Neurofibromatosis ____Other:
Hematological: **None**____ ____ Anemia ____ Leukemia ____ Other:	**Gastrointestinal:** **None**____ ____ Crohn's ____ Colitis ____ Other:	**Ear/ Nose/ Throat:** **None**____ ____ Hearing Loss ____ Upper Resp. Infection ____ Other:
Dermatologic: **None**____ ____ Eczema ____ Rosacea ____ Psoriasis ____Other:	**Allergies** (please list): **None**____ Drug: Environmental:	**Alcohol Use:** Yes No Amount:_____ **Tobacco Use:** Yes No Amount:_____

Please list physical reactions to above allergies:_____

Please list any medications/ drugs/ vitamins that you are taking and for what condition:

1._____ for_____ 5._____for_____

2._____for _____ 6._____for_____

3._____for_____ 7._____for_____

4._____for _____ 8._____for_____

Family History: Has anyone in your family (grandparents, parents, siblings, children) been diagnosed with:

Disease/ Condition:

Retinal Detachment:	Yes/ No	Who:_____	Blindness:	Yes/ No	Who:_____
High Blood Pressure:	Yes/ No	Who:_____	Cataracts:	Yes/ No	Who:_____
Diabetes:	Yes/ No	Who:_____	Glaucoma:	Yes/ No	Who:_____
Thyroid Disease:	Yes/ No	Who:_____	Crossed Eyes:	Yes/ No	Who:_____
Heart Disease:	Yes/ No	Who:_____	Lupus:	Yes/ No	Who:_____
Macular Degeneration:	Yes/ No	Who:_____	Cancer:	Yes/ No	Who:_____

Reviewed By:

Patient Signature:_____ Date:_____

Doctor Signature:_____ Date:_____