Today's Date _____ / _____ / _____

ADULT HEALTH HISTORY

All information provided on this form is used exclusively for your medical care. This information is needed for insurance and diagnostics and will not be shared with any other party unless you authorize Alpine Vision Center to do so.

Last _____ First _____ MI _____

Date of Birth _____ / _____ / _____ Social Security# _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Phone Home _____ Work _____ Cell _____

Email _____ Sex ☐Male ☐Female ☐Non-binary

Occupation _____ Employer _____

Preferred Pharmacy _____

Preferred Method of Contact

☐Phone ☐Text ☐Email ☐Postal

(Email is only used for appointment reminders and to notify if glasses or contacts are here)

Marital Status

☐Single ☐Married ☐Separated

☐Divorced ☐Domestic Partnership ☐Widowed

Race

☐White ☐American Indian or Alaska Native

☐Black or African American ☐Asian

☐Native Hawaiian or other Pacific Islander

☐Hispanic or Latino ☐Other _____

Ethnicity

☐Native Hawaiian or other Pacific Islander

☐Hispanic or Latino ☐Not Hispanic or Latino

Preferred Language

☐English ☐Spanish ☐French

☐Japanese ☐Other _____

How did you choose our office?

☐Referred by _____

☐Online ☐Doctor Recommendation

☐Insurance Listing ☐Drive By

☐Newspaper/Radio/TV ☐Directory

INSURANCE

☐**Primary Medical Insurance** _____

Subscriber ID _____ Group Name _____

Subscriber Name *(if different than above)* _____ Date of Birth _____ / _____ / _____

Address *(if different than above)* _____ City _____ Zip _____

☐**Vision Insurance** _____

Subscriber ID _____ Group Name _____

Subscriber Name *(if different than above)* _____ Date of Birth _____ / _____ / _____

Address *(if different than above)* _____ City _____ Zip _____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? ☐No ☐Yes. Do you have visual difficulty when driving? ☐No ☐Yes

If yes, please describe: _____

Do you use tobacco products? ☐No ☐Yes. Type/amount/how long: _____

Do you drink alcohol? ☐No ☐Yes. Quantity of drinks per day: _____

Do you use any other substances? ☐No ☐Yes. Type/how often: _____

ALPINE VISION CENTER

FAMILY HISTORY

Please select any family history *(parents, grandparents, siblings, children: living or deceased)* for the following conditions. *(If you select any of the following please tell us whom.)*

OCULAR

- ☐Blindness _____
- ☐Cataract _____
- ☐Crossed Eyes _____
- ☐Glaucoma _____
- ☐Macular Degeneration _____
- ☐Retinal Detachment/Disease _____
- ☐Other _____

SYSTEMIC

- ☐Arthritis _____
- ☐Cancer _____
- ☐Diabetes _____
- ☐Heart Disease _____
- ☐High Blood Pressure _____
- ☐Kidney Disease _____
- ☐Lupus _____
- ☐Thyroid Disease _____
- ☐Other _____

REVIEW OF SYSTEMS

Please select any of the following condition you have experienced chronically:

- ☐Dry Eyes
- ☐Loss of Vision
- ☐Blurred Vision
- ☐Distorted Vision/Halos
- ☐Double Vision
- ☐Excess Tearing/Watering
- ☐Glare/Light Sensitivity
- ☐Eye Pain or Soreness
- ☐Chronic Infection of Eye or Lid
- ☐Sties or Chalazion
- ☐Flashers/Floaters in Vision
- ☐Tired Eyes
- ☐Diabetes
- ☐Headaches
- ☐Migraines
- ☐Allergies/Hay Fever
- ☐Sleep Apnea
- ☐Emphysema
- ☐Respiratory
- ☐Asthma
- ☐Heart Pain
- ☐Integumentary (Skin)
- ☐High Blood Pressure
- ☐Cardiovascular Disease
- ☐Sinus Congestion
- ☐Runny Nose
- ☐Neurological
- ☐Rheumatoid Arthritis
- ☐Arthritis
- ☐Chronic Cough
- ☐Muscle Pain
- ☐Seizures
- ☐Joint Pain
- ☐Dry Throat/Mouth
- ☐Endocrine
- ☐Anemia
- ☐Thyroid/Other Glands
- ☐Psychiatric
- ☐Fever, Weight loss/gain
- ☐Cancer
  Type: _____
- ☐Other: _____

MEDICAL HISTORY

Primary Care Physician _____ Phone _____

Date of Last Eye Exam ____ / ____ / ____ Date of Last Physical ____ / ____ / ____

Do you have any allergies to medications? ☐No ☐Yes. Please explain: _____

Are you pregnant and/or nursing? ☐No ☐Yes

List any medications you take *(including oral contraceptives, aspirin, over the counter medications and home remedies):*

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Do you wear glasses? ☐No ☐Yes. How old is your present pair of lenses? _____

Do you wear contact lenses? ☐No ☐Yes. Are you Satisfied with your contact lenses? ☐No ☐Yes

Type/Brand _____ Days Worn per Week _____ Hours per Day _____

Do you sleep in your contacts? ☐No ☐Yes. How often do you replace/dispose your lenses? _____

Have you had any of the following: ☐Crossed Eyes ☐Lazy Eye ☐Drooping Eyelid ☐Prominent Eyes ☐Glaucoma ☐Retinal Disease ☐Cataracts ☐Eye Surgeries ☐Eye Infections ☐Eye Injury

Do you use eye drops? ☐No ☐Yes. How often? _____

_____ ____ / ____ / ____

Signature Date

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