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?_____

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

( ) Blurred vision at near	( ) Itchy, Burning, Red	( ) Floaters
( ) Blurred vision at distance	( ) Burning eyes	( ) Color vision difficulties
( ) Eye pain / Pressure	( ) Dry eyes	( ) Night vision problems
( ) Red eyes	( ) Discharge from eyes	( ) Extreme light sensitivity
( ) Watery / Discharge	( ) Headaches / Migraines	( ) Other_____

Eye Disease: Do you **now**, or have you **ever** had, any of the following eye complications?

( ) Diabetic Retinopathy	( ) Cataract	( ) Lasik/ PRK
( ) Macular Degeneration	Surgery Date: _____	Surgery date:_____
Wet or Dry?_____	( ) Amblyopia	( ) Other:_____
( ) Glaucoma	( ) Eye injury:_____	
Name of Drops?_____	( ) Eye surgery:_____	

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	( ) Thyroid disease	( ) Concussions / TBI
( ) Heart disease	( ) Stroke / Neurological disease	( ) Respiratory
( ) ADD / ADHD	( ) Ear / Mouth / Nose / Throat	( ) Other:_____

( ) Cancer: Type:_____ Diagnosis Year:_____ Remission: ( ) Yes ( ) No
( ) Diabetes: Onset Year:_____ 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:
_____

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