Patient History Form Vision Source of Worcester and Spencer

Patient Name: _____DOB: _____ Todays Date:_____

PhoneNumber: _____ Address: _____

Primary Care: _____ Last PCP Visit:_____

Medical Insurance: _____ Vision Plan: _____

Medical Changes Since Last Visit

New Medical Conditions: No/Yes_____

Surgeries/Hospitalizations: No/Yes _____
Medications/Supplements/Vitamins: If "long list," please bring a copy to scan in:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical Allergies: No/Yes_____

Family Eye History: Glaucoma No/Yes **Macula Degeneration** No/Yes Other_____

Medical History Review Circle all that apply

Diabetes - High Blood Pressure - High Cholesterol - Thyroid Disease - Heart Disease -
Autoimmune - Asthma - Neurological - Autism - Attention Disorder - Cancer_____
Other_____

Current Vision Concerns: Circle all that Apply
Blurry Vision Distance - Blurry Vision Reading - Double Vision - Eye Pain - Light Sensitivity

Dry Eye Concerns Circle all that Apply: Sandy-Gritty- Burning-Watering - Fluctuating vision

How often do you get headaches? Never/Occasionally/Often

How many hours do you spend on the computer? _____ Hours **Computer Glasses?**Yes No

Do you have sun glasses? Yes No **Do you have safety glasses?** Yes No

Do you play sports? Yes No **Do you have any hobbies? _____**

Contact Lenses: Circle all that apply
Do you wear Contact Lenses: Yes or No or Interested in trying Contacts
How often do you wear them? Every Day - Often - Rarely
How many hours can you comfortably wear them? ____ Hours
Do you take advantage of the Contact lens rebates? Yes No

How would you Rate Your Hearing: (Poor 1 to 5 Great) _____

Vision Source