Today's Date_____ Primary Phone_____
Home Cell Work

Last_____ Secondary Phone_____
Home Cell Work

First_____ Email_____

MI_____ Sex M F Occupation _____

Preferred Name _____ Referred By _____

Date of Birth _____ Race_____

Address_____ Ethnicity_____

_____ Preferred Language_____


**Reason for Visit**

- ☐ Diabetic Exam
- ☐ Eye Exam
- ☐ Contact Lens Exam
- ☐ Other
- ☐ Urgent Eye Issue

# Health History

To help our office better serve your specific needs, please check all that apply.

## Eye History

| Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Headaches | ☐ | ☐ | Glare/Light Sensitivity | ☐ | ☐ | Tired Eyes | ☐ | ☐ | Amblyopia(lazy eye) |
| ☐ | ☐ | Eye Infection | ☐ | ☐ | Excessive Tearing/Watering | ☐ | ☐ | Redness | ☐ | ☐ | Eye Pain or Soreness |
| ☐ | ☐ | Drooping Eyelid | ☐ | ☐ | Sandy or Gritty Feeling | ☐ | ☐ | Itching | ☐ | ☐ | Fluctuating Vision |
| ☐ | ☐ | Crossed Eyes | ☐ | ☐ | Blurred Vision Distance | ☐ | ☐ | Dryness | ☐ | ☐ | Double Vision |
| ☐ | ☐ | Floaters or Spots | ☐ | ☐ | Blurred Vision Near | ☐ | ☐ | Burning | ☐ | ☐ | Distorted Vision (Halos) |
| ☐ | ☐ | Loss of Side Vision | ☐ | ☐ | Foreign Body Sensation | ☐ | ☐ | Loss of Vision | ☐ | ☐ | Mucous Discharge |
| ☐ | ☐ | Macular Degeneration | ☐ | ☐ | Retinal Detachment | ☐ | ☐ | Glaucoma | ☐ | ☐ | Cataract(s) |
| ☐ | ☐ | Color Blindness | ☐ | ☐ | Blindness | ☐ | ☐ | Diabetic Retinopathy | ☐ | ☐ | Other |

## Medical History

| Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Gastrointestinal | ☐ | ☐ | Musculoskeletal | ☐ | ☐ | Hypertension |
| ☐ | ☐ | Ears, Nose, Throat | ☐ | ☐ | Psychiatric | ☐ | ☐ | Cholesterol |
| ☐ | ☐ | Neurological | ☐ | ☐ | Stroke | | | |
| ☐ | ☐ | Pregnant or Nursing | ☐ | ☐ | Cardiovascular Disease | | | |
| ☐ | ☐ | Bleeding Problems | ☐ | ☐ | Genitourinary | | | |
| ☐ | ☐ | Diabetes **A1C:**_____ | ☐ | ☐ | Cancer | | | |
| ☐ | ☐ | Allergies | ☐ | ☐ | AIDS/HIV | | | |
| ☐ | ☐ | Skin | ☐ | ☐ | Respiratory (Asthma) | | | |
| ☐ | ☐ | Thyroid | ☐ | ☐ | Other System | | | |

### Social History

| Y | N | |
|---|---|---|
| ☐ | ☐ | Smoke Cigarettes |
| ☐ | ☐ | Alcoholic Beverages |

## Family Eye History

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| ☐ | ☐ | Blindness | ☐ | ☐ | Cataract(s) |
| ☐ | ☐ | Amblyopia(lazy eye) | ☐ | ☐ | Macular Degeneration |
| ☐ | ☐ | Glaucoma | ☐ | ☐ | Retinal Detachment |
| ☐ | ☐ | Crossed Eyes | ☐ | ☐ | Diabetic Retinopathy |
| ☐ | ☐ | Color Blindness | ☐ | ☐ | Other_____ |

## Family Medical History

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| ☐ | ☐ | Cancer | ☐ | ☐ | Heart Disease |
| ☐ | ☐ | Stroke | ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Thyroid Disease |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Other_____ |
| ☐ | ☐ | Diabetes | | | |

## Currently Taking Medications *(Prescription and Over the Counter)*

1 _____ for _____
2 _____ for _____
3 _____ for _____
4 _____ for _____
5 _____ for _____
6 _____ for _____

**Allergies**:_____

| PCP Name and Address | Date of Last Physical | Pharmacy Name and Address |
|---|---|---|
| _____ | _____ | _____ |
| _____ | **Date of Last Eye Exam** | _____ |
| _____ | _____ | _____ |

**Signature** _____ **O.D. Initials** _____