

PATIENT HISTORY FORM

Name: _____ DOB: ____/____/____ Age: _____ Exam Date: ____/____/____

When was your last eye exam? _____ By whom? _____

MEDICAL & FAMILY HISTORY

Have you had any surgeries? Y/N Please list: _____
 Are you taking any medications? Y/N Please list: _____
 Are you allergic to any medications? Y/N Please list: _____
 Females: Are you pregnant or nursing? Y/N

Have you or a relative been diagnosed with the following? If answering yes for yourself, please indicate the year in which you were diagnosed.

<input type="checkbox"/> Cataracts	Family member _____	Self _____	Diagnosed _____
<input type="checkbox"/> Macular Degeneration	Family member _____	Self _____	Diagnosed _____
<input type="checkbox"/> Turned Eyes	Family member _____	Self _____	Diagnosed _____
<input type="checkbox"/> Diabetes	Family member _____	Self _____	Diagnosed _____
<input type="checkbox"/> High Blood Pressure	Family member _____	Self _____	Diagnosed _____
<input type="checkbox"/> Glaucoma	Family member _____	Self _____	Diagnosed _____

Do you experience any of the following: Blurred Vision Itching Double Vision Eye Strain/ Pain Dry Eye
 Headaches Flashes Floaters Glare/ light sensitivity
 Other related eye problems or eye surgeries? _____

SOCIAL HISTORY

Occupation _____ Hobbies / Interests _____
 Does your occupation or hobby require special eyewear? Y/N Please explain _____

PATIENT HISTORY

Constitutional None _____	Musculoskeletal None _____	CONTACT LENSES
<input type="checkbox"/> Developmental disability <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Trauma Cardiovascular None _____ <input type="checkbox"/> Stroke <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure Respiratory None _____ <input type="checkbox"/> Upper respiratory infection <input type="checkbox"/> Cigarette smoker <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema Gastrointestinal None _____ <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcer Genitourinary None _____ <input type="checkbox"/> Urinary tract infection <input type="checkbox"/> STD Integumentary None _____ <input type="checkbox"/> Eczema Rosacea	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Fibromyalgia Immunological None _____ <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> AIDS Neurological None _____ <input type="checkbox"/> MS <input type="checkbox"/> Epilepsy Psychiatric None _____ <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Panic disorder Endocrine None _____ <input type="checkbox"/> Insulin dependent diabetes <input type="checkbox"/> Non-insulin dep diabetes <input type="checkbox"/> Thyroid dysfunction Other <input type="checkbox"/> _____ Doctor's Initials _____	If you DO NOT wear contacts: <input type="checkbox"/> I have never worn contacts <input type="checkbox"/> I am not interested in contacts <input type="checkbox"/> I would like to know my options If you DO wear contacts: What type of contacts do you wear? <input type="checkbox"/> Daily wear <input type="checkbox"/> Extended wear <input type="checkbox"/> Soft <input type="checkbox"/> RGP <input type="checkbox"/> Toric (for astigmatism) <input type="checkbox"/> Monovision <input type="checkbox"/> Bifocal Brand of contacts: _____ What brand of solution do you use? _____ How long have your current contacts been on your eyes? _____ hours _____ days Please list any contact lens complaints _____ _____