

Patient Health History (This information is important for medical purposes as well as compliance with *insurance* directives.)

Chief Complaint:

How can we help you today? Please briefly tell us any signs and symptoms you are experiencing.

(Medical insurance will only cover if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, eye itching or burning, glaucoma, cataracts, floaters, dry eyes.)

Personal Eye Information

Do you have any eye conditions or problems? Yes/No _____ What kind? _____

Have you had any eye operations? Yes / No _____ Type _____ Date _____

Have you had any eye injury? Yes / No _____ Kind _____ Date _____

Do you have glaucoma? Yes / No _____ Cataracts? Yes / No _____ Date of last eye exam ____/____/____

Macular degeneration? Yes / No _____ Retinal detachment Yes / No _____ Dilated? Yes / No _____

Do you wear glasses? Yes / No _____ Contact lenses? Yes / No _____ Brand of contacts _____

Additional information _____

Do you experience (check those that apply)

- Burning Soreness Dryness
- Itchiness Eye Strain Blurry distance vision
- Watery eyes Redness Blurry near vision
- Double Vision Sensitivity to light Objects floating in vision
- Flashes of light Sudden loss of vision Trouble seeing at night
- Glare or reflection Gritty feeling in eyes Uncomfortable glasses

Medical History

- Allergies Arthritis Skin disorder
- Asthma Cancer High blood pressure
- Diabetes Kidney problems Thyroid
- Nerves Heart disease Other _____

Please mark the significant health history below:

Gastrointestinal None____
__ Crohn's
__ colitis
__ ulcer
__ digestive

Neurological None ____
__ multiple sclerosis
__ epilepsy

Integumentary None____
__ eczema
__ rosacea
__ psoriasis

Constitutional None____
__ development disability
__ weight loss
__ fever
__ fatigue
__ trauma

Ear, Nose & Throat None____
__ upper respiratory infection

Psychiatric None____
__ depression
__ panic disorder
__ schizophrenia

Endocrine None____
__ Non-insulin dependent diabetes
__ insulin dependent diabetes
__ thyroid dysfunction
__ hormonal dysfunction

Current Medications:

Cardiovascular None____
__ heart disease
__ hypertension
__ stroke
__ vascular disease

Genitourinary None____
__ urinary tract infections
__ kidney ailments
__ STD/viral
herpetic, Chlamydia

Hematological/Lymphatic None____
__ anemia
__ large volume blood loss
__ leukemia

Respiratory None____
__ cigarette smoker
__ asthma
__ bronchitis
__ emphysema

Musculoskeletal None____
__ fibromyalgia
__ muscular dystrophy
__ osteoarthritis
__ ankylosing spondylitis

Allergic/Immunologic None____
__ drug allergy
__ environmental allergy
__ rheumatoid arthritis
__ lupus

Social history: Do you use tobacco products? Yes No Do you drink alcohol? Yes No

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Family History

High blood pressure Yes/No Relation _____ Macular degeneration Yes/No Relation _____
Diabetes Yes/No Relation _____ Retinal detachment Yes/No Relation _____
Glaucoma Yes/No Relation _____ Cataracts Yes/No Relation _____