Patient History Form

Date: _____

Name: _____Date of Birth: _____

Email Address: _____

Do you wear glasses/contact lenses for:

☐ distance (driving, television, sports events)

☐ intermediate (computer, shopping, sheet music)

☐ near (reading, needlepoint)

Are you satisfied with the clarity of your vision with current glasses/contacts?

☐ Yes

☐ No, please explain_____

Are you experiencing any of the following: (check all that apply)

☐ Blurred vision	☐ Redness	☐ Burning	☐ Itching
☐ Eye strain	☐ Eye pain	☐ Tearing	☐ Discharge
☐ Headaches	☐ Flashes	☐ Floaters	☐ Double vision
☐ Severe sensitivity to lights	☐ Bothersome glare		☐ Dry Eye
☐ Poor night vision	☐ Total loss of vision		

☐ Other_____

Please list ALL current medications, supplements, and vitamins (including dosage) Or Attach List

_____

_____

_____

_____

Primary Care Physician/Clinic: _____Date of last physical_______

Interests: (check all that apply)

☐ New eyeglasses	☐ Reading glasses
☐ Prescription sunglasses	☐ Safety glasses
☐ Non-prescription sunglasses	☐ New supply of contact lenses
☐ Computer glasses	☐ New fitting of contact lenses
☐ Sports (including hunting, swimming, motorcycle)	

OVER →

Review of Systems (<u>check all that apply</u>):

(Constitution) ☐ developmental disabilities ☐ cancer ☐ fatigue Syndrome

(ENT) ☐ hearing loss ☐ sinusitis ☐ dry mouth ☐ laryngitis

(Neurologic) ☐ multiple sclerosis ☐ epilepsy ☐ cerebral palsy ☐ tumor ☐ stroke/CVA ☐ migraine, ☐ autism spectrum disorder

(Psychiatric) ☐ depression ☐ attention deficit ☐ anxiety ☐ bipolar disorder

(Cardiovascular) ☐ **hypertension** ☐ stroke/CVA ☐ heart disease ☐ vascular disease ☐ congestive heart failure

(Respiratory) ☐ cigarette smoker ☐ asthma ☐ bronchitis ☐ emphysema ☐ chronic obstruction ☐ sleep apnea

(GI) ☐ Crohn's ☐ colitis ☐ ulcer ☐ acid reflux ☐ celiac disease

(GU) ☐ kidney disease ☐ prostate disease/cancer ☐ STD (herpetic/Chlamydia), ☐ benign prostate hypertrophy ☐ herpes ☐ Chlamydia ☐ **pregnant/nursing (_____delivery date)**

(Musculoskeletal) ☐ osteoarthritis ☐ arthritis ☐ fibromyalgia ☐ muscular dystrophy ☐ ankylosing spondylitis ☐ osteoporosis ☐ gout

(Integumentary) ☐ eczema ☐ rosacea ☐ psoriasis ☐ herpes simplex (cold sores) ☐ herpes zoster (shingles)

(Endocrine) ☐ **type 2 diabetes mellitus** ☐ **type 1 diabetes mellitus** ☐ thyroid dysfunction ☐ hormonal dysfunction

(Hematic/Lymphatic) ☐ anemia ☐ large volume blood loss ☐ ulcer ☐ **high cholesterol**

(Allergy/Immune) ☐ **drug allergies** ☐ **environmental allergies** ☐ rheumatoid arthritis ☐ lupus, ☐ Sjogren's syndrome

<u>Family (parents, siblings, children)</u> Medical History: ***(check all that apply)***

☐ Cancer ☐ Diabetes ☐ Hypertension ☐ High Cholesterol ☐ Hyperthyroidism ☐ Hypothyroidism

<u>Family (parents, siblings, children)</u> Ocular History: ***(check all that apply)***

☐ Amblyopia ☐ Cataract ☐ Macular Degeneration ☐ Glaucoma ☐ Retinal Detachment ☐ Strabismus

Social History:

- Alcohol Use: ☐ Never ☐ Occasional ☐ Daily
- Tobacco Use: □ Never □ Previous □ Current
  - Tobacco Type_____ How often_____