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FAMILY EYE CARE

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Optometrists

Patient History Form

Patient's name: ____ Date: ______/_______/_______
☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Rev

Address: ____ Birth date: _____/_____/______

____ SSN: ______________________

Email address: ____ Home phone: _______________

Occupation: ____ Cell phone: _________________

Employer: ____ Work phone: _________________

Primary care physician: ________________________________ Last medical exam: ___/___/___

Previous eye doctor: __________________________________ Last eye exam: ____/____/____

Responsible party: ____________________________________ Relationship: _______________

Referred by: ____ Medical insurance: ___________

Reason for today's visit: ______________________________________

Ocular History

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your current pair of lenses? ____________________

Do you wear contact lenses? ☐ No ☐ Yes If yes, what type? ☐ Rigid gas permeable ☐ Soft ☐ Toric
☐ Scleral ☐ Hybrid ☐ Monovision ☐ Multifocal ☐ Extended wear

Do you wear your contacts ☐ Full time ☐ Part time How frequently do you replace them? _____________

Have you had refractive surgery? ☐ No ☐ Yes If yes, Date ____/_____/_____ Type ____________________

What other services would you like to be evaluated for? ☐ Refractive surgery (i.e. LASIK, PRK) ☐ Sunglasses
☐ Contact lenses ☐ Computer glasses ☐ Reading glasses ☐ Driving glasses ☐ Vision therapy ☐ Other

Are you currently experiencing any of the following problems with your eyes? Check all that apply

☐ Blurred distance vision	☐ Headaches	☐ Redness
☐ Blurred near vision	☐ Pain / soreness	☐ Dryness
☐ Double vision	☐ Halos / glare / light sensitivity	☐ Itch
☐ Tired eyes / eyestrain	☐ Flashes / floaters in vision	☐ Other ___________________

Have you ever been diagnosed with the following ocular problems? Circle all that apply

☐ Cataracts ☐ Eye turn (strabismus) ☐ Retinal detachment / disease ☐ Eye injury
☐ Glaucoma ☐ Lazy eye (amblyopia) ☐ Dry eye ☐ Other __________________________

Medical History

List all current medications and dosages (including over-the-counter medications): ___________________________

____

____

List all allergies (environmental and medication allergies): ____

Review of Systems Check all that conditions that currently apply to your health

Constitutional ☐ All normal	**Musculoskeletal** ☐ All normal	**Integumentary (skin)** ☐ All normal
☐ Fever or chills ☐ Weight loss or gain ☐ Other ____________________	☐ Muscle pain ☐ Arthritis ☐ Other ________________________	☐ Rashes ☐ Skin cancer ☐ Other ______________________
Neurological ☐ All normal	**Genitourinary** ☐ All normal	**Gastrointestinal** ☐ All normal
☐ Migraines ☐ Dizziness ☐ Seizures ☐ Other ____________________	☐ Kidney disease ☐ Prostate cancer ☐ Ovarian disease ☐ Other ________________________	☐ Diarrhea ☐ Constipation ☐ IBS / Crohn's disease ☐ Other ______________________
Psychiatric ☐ All normal	**Ear, nose and throat** ☐ All normal	**Endocrine** ☐ All normal
☐ Anxiety ☐ Depression ☐ Stress ☐ Other ____________________	☐ Sinus congestion ☐ Dry mouth / throat ☐ Hearing loss ☐ Other ________________________	☐ Diabetes ☐ Thyroid dysfunction ☐ Heat or cold intolerance ☐ Other ______________________
Cardiovascular ☐ All normal	**Hematologic / Lymphatic** ☐ All normal	**Allergic / Immunologic** ☐ All normal
☐ High blood pressure ☐ Stroke / CVA ☐ Heart disease ☐ Other ____________________	☐ Anemia ☐ Clotting problems ☐ High cholesterol ☐ Other ________________________	☐ Environmental allergies ☐ Medicine allergies ☐ HIV / AIDS ☐ Other ______________________
Respiratory ☐ All normal	If you have any conditions not listed above, please include them below:	
☐ Cough ☐ Shortness of breath ☐ Asthma ☐ Other ____________________	Are you pregnant or nursing? ☐ No ☐ Yes	

Family History

Diabetes ☐ No ☐ Yes Relation __________________

Heart Disease ☐ No ☐ Yes Relation _____________

Cancer ☐ No ☐ Yes Relation __________________

Macular degeneration ☐ No ☐ Yes Relation ______________

Glaucoma ☐ No ☐ Yes Relation________________________

Retinal disease ☐ No ☐ Yes Relation ____________________

Social History

Hobbies, sports, activities:____

Do you use any tobacco products? ☐ No ☐ Yes Type, amount _____________________

Do you consume alcohol? ☐ No ☐ Yes Type, amount _____________________________

Do you use any recreational drugs? ☐ No ☐ Yes Type, amount ____________________

Signature: ____ **Date:** _____/_____/_____