Patient History Form

Name: _____ Today's Date: _____

Date of birth: _____ Age: _____How did you hear about us: _____

Phone: (home) _____ (work) _____ (cell) _____

Primary Care Physician:

Name: _____

Address: _____

_____

Phone: _____

Other healthcare providers you wish us to communicate with:

Name: _____

Address: _____

_____

Phone: _____

Were you **referred by a doctor** for this visit? Yes / No If yes, who? _____

What **medical/visual problem** brings you here? _____

_____

Eye History: (circle)

Do you wear glasses? Yes / No
Are you looking for a new glasses prescription? Yes / No

Do you wear contact lenses? Yes / No
If YES, are you happy with your current contact lenses? Yes / No
Are you looking for a new contact lens prescription? Yes / No

Have you ever been told you have an eye disease such as amblyopia, "lazy eye", strabismus, macular degeneration, retinal detachment, cataracts, or glaucoma? _____ If so, what? _____

_____

Have you ever had eye surgery or an eye injury? _____ If so, what and when? _____

_____

Do you currently use eye drops? If so, which eyedrops?

Medical History:

Have you recently been vaccinated for Influenza? Y / N
Have you ever been vaccinated for Pneumonia? Y / N

Have you ever been diagnosed with any of the following medical conditions:

	Yes	No		Yes	No
Diabetes	_____	_____	Autoimmune disease	_____	_____
High blood pressure	_____	_____	Arthritis	_____	_____
Heart disease	_____	_____	Headache/migraine	_____	_____
High cholesterol	_____	_____	Seasonal allergies	_____	_____
Stroke	_____	_____	Asthma/COPD/Emphysema	_____	_____
Numbness/Weakness/ Paralysis	_____	_____	Depression/anxiety	_____	_____
			Thyroid	_____	_____
Parkinson's	_____	_____	Cancer	_____	_____
Alzheimer's	_____	_____	Skin disorders	_____	_____
Intestinal disease	_____	_____	Kidney	_____	_____
Cerebral palsy	_____	_____	Blood disorder	_____	_____

Are there any conditions/illnesses you have been treated for that are not listed on this form? _____
If yes, please specify: _____

OVER

Please list all medications you are currently taking: OR ☐ I do not take any medications, over the counter supplements, or vitamins.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list all surgeries you have had: OR ☐ I have not had any surgeries in my lifetime.

_____

_____

_____

_____

Please list any allergies you have to medications: OR ☐ I have no allergies to medications

_____

_____

_____

_____

Family history: M=Mother F=Father S=Sibling G=Grandparent

	Yes	No	Relationship to patient
Glaucoma	_____	_____	_____
Macular degeneration	_____	_____	_____
Retinal disease	_____	_____	_____
Strabismus	_____	_____	_____
Amblyopia ("lazy eye")	_____	_____	_____
High blood pressure	_____	_____	_____
Heart disease	_____	_____	_____
Diabetes	_____	_____	_____
Lupus	_____	_____	_____
Arthritis	_____	_____	_____
Thyroid	_____	_____	_____
Cancer	_____	_____	_____

Are there any conditions/illnesses for family members not listed on this form? YES / NO

If yes, please specify: _____

Social History:

Occupation: _____

Marital Status: (circle) Single Married Divorced Widowed

Do you smoke? (circle) Yes No Amount: _____

Do you drink alcohol? (circle) Yes No Amount: _____

Do you have a history of substance abuse? (circle) Yes No