

Dear Patient:

All major health insurers and Medicare now require us to obtain in-depth patient medical history information. We apologize for the time required to fill out this form and thank you for your cooperation.

Name _____ Today's Date: ____/____/____

EYE AND HEALTH HISTORY

Reason for Visit routine annual exam need new glasses lost or broken glasses
 contact lenses interested in lasik laser vision correction

Do you have any specific questions or problems you would like to discuss with your doctor? yes no
 If "yes," please explain: _____

Are you currently taking any medications? yes no

If "yes," please list: _____

Are you allergic to any medications? yes no

If "yes," please explain: _____

Are you pregnant and/or nursing? yes no _____

PERSONAL EYE HISTORY

Date of Last Eye Examination: _____ Doctor's Name: _____

Have you ever worn glasses? yes no If "yes," how old are your current glasses? _____

Do you currently wear contact lenses? yes no

Type of contact lenses: disposables gas perm soft bifocal other _____

What type of solution do you use to clean and disinfect? _____

Have you worn contact lenses in the past? yes no If "yes," please tell us why you quit _____

Have you ever had lasik or retractive surgery? yes no If yes, date: ____/____/____

Have you ever had eye surgery? yes no If "yes," please describe: _____

Check any of the following that you have had: crossed eyes lazy eye drooping eyelid
 prominent eyes glaucoma retinal disease
 cataracts eye injury serious eye infection

How many hours a day do you work on a computer? _____

Please check all applicable items:

Blurred distance vision	Eyes feel dry	Headaches
Blurred intermediate vision	Pain in eyes	Light sensitivity
Blurred near vision	Flashes of lights	Eyes water
Night vision problems	Floating spots in vision	Eyes itch
Double vision	Eyes feel tired	

Please mark those activities in which you participate:

Tennis	Basketball	Skiing	Football	Dancing	Woodworking
Soccer	Swimming	Hunting	Fishing	Golf	Rollerblading
Biking	Racquetball	Walking	Scuba Diving	Reading	Baseball
Gardening	Crafts	Jogging	Sewing	Aerobics	Musical Instrument

REVIEW OF SYSTEMS

Do you currently, or have you ever, had any serious problems in the following areas:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (Thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Neurological (Headaches)	<input type="checkbox"/>	<input type="checkbox"/>	Ears, Nose, Mouth, Throat (Allergies)	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Allergic/Immune	<input type="checkbox"/>	<input type="checkbox"/>	Mental	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

Have you been exposed to or infected with any of the following:

- Lyme Disease
 HIV
 Hepatitis

If you answered "yes" to any of the above or are currently under the care of a physician for any condition not listed above, please explain: _____

Physician's Name: _____ Phone #: _____

SOCIAL HISTORY

This information is kept strictly confidential. Please answer all questions that apply.

Do you drive? yes no If "yes," do you have visual difficulty when driving? yes no
 If "yes," please describe: _____

Do you use tobacco products? yes no Do you drink alcohol? yes no
 Do you use illegal drugs? yes no

FAMILY HISTORY

Please note any family history (parents, grandparents, sibling, children: living or deceased) for the following conditions:

<u>Disease/Condition</u>	<u>Yes</u>	<u>No</u>	<u>Relationship to You</u>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____			

I acknowledge that I have been made aware of the HIPPA Notice of Privacy Practices.

Patient Name: _____ Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____