# PATIENT HISTORY FORM

Name: _____ D.O.B: _____ Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer/Occupation: _____ Email: _____

Do you have vision insurance? ☐No ☐Yes If Yes, Provider? _____

Do you have health insurance? ☐No ☐Yes If Yes, Provider? _____

Do you have medicare? ☐No ☐Yes

## *Medical History*

Date of last eye exam: _____ By Whom: _____

Who is your family doctor? _____

Do you have any allergies to medication? ☐No ☐Yes If yes, explain _____

_____

List medications you take (including oral contraceptives, aspirin, over-the-counter meds, and home remedies)

_____

_____

_____

List all major injuries, surgeries, and/or hospitalizations you have had _____

_____

List any of the following that you have had - crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye injury _____

_____

Are you pregnant and/or nursing? ☐No ☐Yes

Do you wear glasses? ☐No ☐Yes If yes, how are your lenses? _____

Do you wear contact lenses? ☐No ☐Yes If yes, how are your lenses? _____

Contact lens type: ☐Rigid ☐Soft ☐Extended Wear ☐Other Are they comfortable? ☐No ☐Yes

Contact lens disinfection type: _____

## *Family History*

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

| Disease/Condition | No | Yes | ? | Relationship |
|---|---|---|---|---|
| Blindness | ☐ | ☐ | ☐ | |
| Cataract | ☐ | ☐ | ☐ | |
| Cross Eyes | ☐ | ☐ | ☐ | |
| Glaucoma | ☐ | ☐ | ☐ | |
| Macular Degeneration | ☐ | ☐ | ☐ | |
| Retinal Detachment/Disease | ☐ | ☐ | ☐ | |
| Arthritis | ☐ | ☐ | ☐ | |
| Cancer | ☐ | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | ☐ | |
| Heart Disease | ☐ | ☐ | ☐ | |
| High Blood Pressure | ☐ | ☐ | ☐ | |
| Kidney Disease | ☐ | ☐ | ☐ | |
| Lupus | ☐ | ☐ | ☐ | |
| Thyroid Disease | ☐ | ☐ | ☐ | |
| Other | ☐ | ☐ | ☐ | |

*Re-Order Item# 9907008*
*Standard Tab Exam Form*

## *Social History*

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? ☐No ☐Yes If yes, do you have visual difficulty when driving? ☐No ☐Yes

If yes, explain _____

Do you use tobacco products? ☐No ☐Yes If yes, type/amount/how long _____

Do you drink alcohol? ☐No ☐Yes If yes, type/amount/how long _____

Do you use illegal drugs? ☐No ☐Yes If yes, type/amount/how long _____

Have you ever been exposed to or infected with: ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis

Do you work on a computer? ☐No ☐Yes

Do you work under fluorescent lighting? ☐No ☐Yes

Do you have trouble with glare? ☐No ☐Yes

Do you participate in sports that require eye protection? ☐No ☐Yes

Would you like to try contacts? ☐No ☐Yes

## *Review of Systems*

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

| ***Constitutional*** | No | Yes | ? | ***Ear, Nose, Mouth, Throat*** | No | Yes | ? |
|---|---|---|---|---|---|---|---|
| Fever, Weight Loss/Gain | ☐ | ☐ | ☐ | Allergies/Hay Fever | ☐ | ☐ | ☐ |
| ***Integumentary*** | | | | Sinus Congestion | ☐ | ☐ | ☐ |
| Skin | ☐ | ☐ | ☐ | Runny Nose | ☐ | ☐ | ☐ |
| ***Neurological*** | | | | Post-Nasal Drip | ☐ | ☐ | ☐ |
| Headaches | ☐ | ☐ | ☐ | Chronic Cough | ☐ | ☐ | ☐ |
| Migraines | ☐ | ☐ | ☐ | Dry Throat/Mouth | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ | ***Respiratory*** | | | |
| ***Eyes*** | | | | Asthma | ☐ | ☐ | ☐ |
| Loss of Vision | ☐ | ☐ | ☐ | Chronic Bronchitis | ☐ | ☐ | ☐ |
| Blurred Vision | ☐ | ☐ | ☐ | Emphysema | ☐ | ☐ | ☐ |
| Distorted Vision/Halos | ☐ | ☐ | ☐ | ***Vascular/Cardiovascular*** | | | |
| Loss of Side Vision | ☐ | ☐ | ☐ | Diabetes | ☐ | ☐ | ☐ |
| Double Vision | ☐ | ☐ | ☐ | Heart Pain | ☐ | ☐ | ☐ |
| Dryness | ☐ | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | ☐ |
| Mucous Discharge | ☐ | ☐ | ☐ | Vascular Disease | ☐ | ☐ | ☐ |
| Redness | ☐ | ☐ | ☐ | ***Gastrointestinal*** | | | |
| Sandy or Gritty Feeling | ☐ | ☐ | ☐ | Chronic Diarrhea | ☐ | ☐ | ☐ |
| Itching | ☐ | ☐ | ☐ | Chronic Constipation | ☐ | ☐ | ☐ |
| Burning | ☐ | ☐ | ☐ | ***Genitourinary*** | | | |
| Foreign Body Sensation | ☐ | ☐ | ☐ | Gential/Kidney/Bladder | ☐ | ☐ | ☐ |
| Excess Tearing/Watering | ☐ | ☐ | ☐ | ***Bones/Joints/Muscles*** | | | |
| Glare/Light Sensitivity | ☐ | ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ | ☐ |
| Eye Pain or Soreness | ☐ | ☐ | ☐ | Muscle Pain | ☐ | ☐ | ☐ |
| Chronic Infection of Eye or Lid | ☐ | ☐ | ☐ | Joint Pain | ☐ | ☐ | ☐ |
| Stys or Chalazion | ☐ | ☐ | ☐ | ***Lymphatic/Hematologic*** | | | |
| Flashes/Floaters in Vision | ☐ | ☐ | ☐ | Anemia | ☐ | ☐ | ☐ |
| Tired Eyes | ☐ | ☐ | ☐ | Bleeding Problems | ☐ | ☐ | ☐ |
| ***Endocrine*** | | | | ***Allergic/Immunologic*** | ☐ | ☐ | ☐ |
| Thyroid/Other Glands | ☐ | ☐ | ☐ | ***Psychiatric*** | ☐ | ☐ | ☐ |

If you answered yes to any of the above, or have a condition not listed, please explain and list medications:

_____

_____

_____

Doctor's Signature _____ Date _____