HISTORY

Patient Name: _____ Date: _____

EYE HEALTH HISTORY

Date of Last Eye Exam _____

Name of Doctor_____

Do you wear glasses? ☐Yes ☐No

☐All of the time ☐Occasionally

☐Reading ☐Driving ☐TV

Do you wear contacts? ☐Yes ☐No

Type_____

Hours/Day_____

Describe any problems you have with your contacts:

_____

_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bloodshot Eyes	□Yes □No	Floaters or Spots	□Yes □No
Blurred Vision – Near	□Yes □No	Glaucoma	□Yes □No
Blurred Vision – Distance	□Yes □No	Headaches	□Yes □No
Burning Eyes.	□Yes □No	Itching Eyes	□Yes □No
Cataracts	□Yes □No	Light Sensitive	□Yes □No
Color Vision, Poor.	□Yes □No	Loss of Vision	□Yes □No
Crossed Eyes.	□Yes □No	Migraine Headaches	□Yes □No
Discharge from Eyes	□Yes □No	Night Vision, Poor	□Yes □No
Dizzy spells.	□Yes □No	Red Eyes	□Yes □No
Double Vision	□Yes □No	Seeing Halos	□Yes □No
Dry Eyes.	□Yes □No	Seeing Flashes	□Yes □No
Eye Infection	□Yes □No	Temporary Loss of Vision	□Yes □No
Eye injury	□Yes □No	Twitching Eyelid	□Yes □No
Eye Strain	□Yes □No	Vision Poor	□Yes □No

HEALTH HISTORY

Physician's Name: _____ Date of Last Visit: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also, place a mark to indicate if a **blood relative** has had any of the following.

	YOURSELF	FAMILY		YOURSELF	FAMILY
AIDS/HIV	□Yes □No	□Yes □No	Hepatitis (type)	□Yes □No	□Yes □No
Arthritis	□Yes □No	□Yes □No	High Blood Pressure	□Yes □No	□Yes □No
Artificial Heart Val.	□Yes □No	□Yes □No	Kidney Disease	□Yes □No	□Yes □No
Artificial Joints	□Yes □No	□Yes □No	Lazy Eye	□Yes □No	□Yes □No
Asthma	□Yes □No	□Yes □No	Lupus	□Yes □No	□Yes □No
Bleeding	□Yes □No	□Yes □No	Migraine Headaches	□Yes □No	□Yes □No
Blindness	□Yes □No	□Yes □No	Pacemaker	□Yes □No	□Yes □No
Cancer	□Yes □No	□Yes □No	Poor Color Vision	□Yes □No	□Yes □No
Cataracts	□Yes □No	□Yes □No	Retinal Disease	□Yes □No	□Yes □No
Chemical dependency	□Yes □No	□Yes □No	Rheumatic Fever	□Yes □No	□Yes □No
Diabetes	□Yes □No	□Yes □No	Shingles	□Yes □No	□Yes □No
Drug Sensitivity	□Yes □No	□Yes □No	Skin Conditions	□Yes □No	□Yes □No
Emphysema	□Yes □No	□Yes □No	Stroke	□Yes □No	□Yes □No
Epilepsy	□Yes □No	□Yes □No	Thyroid Conditions	□Yes □No	□Yes □No
Eye Surgery	□Yes □No	□Yes □No	Tuberculosis	□Yes □No	□Yes □No
Glaucoma	□Yes □No	□Yes □No	Turned Eye	□Yes □No	□Yes □No
Hay Fever	□Yes □No	□Yes □No	Are you pregnant?	□Yes □No	Number of children _____
Heart condition	□Yes □No	□Yes □No	Tobacco Use	□Yes □No	Alcohol Use □Yes □No
Steroid Treatment in past year?		□Yes □No			

Previous Surgery: □Yes □No Please explain: _____

Anesthesia Problems: □Yes □No Please explain: _____

MEDICATIONS

List any medications you are currently taking, including eye drops: _____

_____

_____

Pharmacy Name _____ Phone _____

ALLERGIES

List your allergies to medications or other substances: _____

REVIEW OF SYSTEMS □NEGATIVE/ I have no bodily complaints

H.E.N.T.:	□Headaches	□Hearing Loss	□Sore Throat	□Voice Change	Comments:_____
Respiratory:	□Chest Pain	□Leg Pain	□Short of Breath	□Varicosities	
	□Cough	□Sputum			Comments:_____
Gastrointestinal:	□Nausea	□Jaundice	□Vomiting	□Blood/Black Stool	
	□Diarrhea	□Weight Loss	□Appetite Change	□Constipation	Comments:_____
Genitourinary:	□Frequency	□Urgency	□Discharge	□Burning	
	□Blood in Urine				Comments:_____
Skeletal:	□Joint Pain	□Muscle Pain	□Joint Restriction	□Back Pain	Comments:_____
Skin:	□Rashes	□Bruises	□Ulcers	□Lesions	Comments:_____
Neurological:	□Numbness/Tingling in hands/feet			□Speech Difficulties	
	□Blackouts	□Convulsions	□Anxiety	□Depression	Comments:_____
Endocrine:	□Thyroid Disease				Comments:_____

Physician's Signature: _____ **Date:** _____