

Name: _____

PATIENT HISTORY AND INFORMATION

Race

<input type="checkbox"/> American Indian Or Alaska Native	<input type="checkbox"/> Other Race	<input type="checkbox"/> Refuse To Specify
<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Not Disclosed
<input type="checkbox"/> Black Or African American	<input type="checkbox"/> Native American	
<input type="checkbox"/> Native Hawaiian Or Other Pacific Islander	<input type="checkbox"/> Caucasian	

Other Race _____

Ethnicity

Hispanic Or Latino Not Hispanic Or Latino Unknown

Preferred Language

English Spanish French Italian Russian Portuguese

Height ft in cm/m ft in cm m Weight lbs kg

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name _____

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name _____

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? _____ When was your last exam ? Apr 28, 1993

When was your last health exam ? _____

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

Current Eye Drops: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

EYE HISTORY

Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Dryness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Crossed Eyes)	<input type="radio"/> Yes <input type="radio"/> No
Cataract	<input type="radio"/> Yes <input type="radio"/> No	Excess Tearing/Watering	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Distance	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Eye Pain or Soreness	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision Near	<input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	Foreign Body Sensation	<input type="radio"/> Yes <input type="radio"/> No	Distorted Vision (halos)	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Infection of Eye or Lid	<input type="radio"/> Yes <input type="radio"/> No	Double Vision	<input type="radio"/> Yes <input type="radio"/> No
Headaches	<input type="radio"/> Yes <input type="radio"/> No	Itching	<input type="radio"/> Yes <input type="radio"/> No	Floaters or Spots	<input type="radio"/> Yes <input type="radio"/> No
Glare/Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No	Fluctuating Vision	<input type="radio"/> Yes <input type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No	Drooping Eyelid	<input type="radio"/> Yes <input type="radio"/> No	Loss of Vision	<input type="radio"/> Yes <input type="radio"/> No
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Redness	<input type="radio"/> Yes <input type="radio"/> No	Loss of Side Vision	<input type="radio"/> Yes <input type="radio"/> No
Burning	<input type="radio"/> Yes <input type="radio"/> No	Sandy or Gritty Feeling	<input type="radio"/> Yes <input type="radio"/> No		

Name: _____

GENERAL HEALTH CONDITION

Fever	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Other Symptoms	<input type="radio"/> Yes <input type="radio"/> No
Ears, Nose, Throat	<input type="radio"/> Yes <input type="radio"/> No
Cardiovascular (high blood pressure etc.)	<input type="radio"/> Yes <input type="radio"/> No

Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No
Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No
Kidney	<input type="radio"/> Yes <input type="radio"/> No
Muscles, Bones, Joints	<input type="radio"/> Yes <input type="radio"/> No
Skin	<input type="radio"/> Yes <input type="radio"/> No
Neurological (Multiple Sclerosis)	<input type="radio"/> Yes <input type="radio"/> No

Anxiety or Depression	<input type="radio"/> Yes <input type="radio"/> No
Thyroid, Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Blood/Lymph	<input type="radio"/> Yes <input type="radio"/> No
Allergic	<input type="radio"/> Yes <input type="radio"/> No
Are you?	<input type="checkbox"/> Pregnant <input type="checkbox"/> Nursing

MEDICAL HISTORY QUESTIONNAIRE

FAMILY HISTORY

Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No
Blindness	<input type="radio"/> Yes <input type="radio"/> No
Cataract(s)	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No

Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No
Strabismus (Eye Turn)	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Heart Disease	<input type="radio"/> Yes <input type="radio"/> No

High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Lupus	<input type="radio"/> Yes <input type="radio"/> No
Stroke	<input type="radio"/> Yes <input type="radio"/> No
Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Others	<input type="radio"/> Yes <input type="radio"/> No

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? Yes No How many hours/day? _____ Distance from Computer? _____

Do you drive? Yes No Mileage to work each way? _____

Do you have glare problems? Yes No

Do you have visual difficulty when driving? Yes No

Do you have problems with night vision? Yes No

Do you currently wear glasses ? Yes No Since _____

Type of glasses FullTime PartTime Distance Close

Glasses Owned SingleVision Bifocals Trifocals Backup Safety Sports Progressive

Have you had trouble in the past with glasses? Yes No _____

Do you wear sunglasses? Yes No Are your sun glasses your current prescription ? Yes No

SPECIAL EYEWEAR NEEDS

Computer (special prescriptions, special anti-glare tints or coatings) Safety Glasses (gardening, woodworking, welding)

Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? Yes No

Have you ever tried to wear contact lenses? Yes No Reason for stopping? _____

Do you currently wear contact lenses? Yes No Since _____

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____
What Solutions do you use?	Cleaner	_____	Disinfectant	_____	Enzyme	_____	_____	_____

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SOCIAL HISTORY

- Do you use nutritional supplements (vitamins etc.)? Yes No
- Do you engage in regular exercise? Yes No
- Do you drink alcohol ? If yes, how much/often : No Occasional 1 Per Day 2-3/day 4+/day
- Do you smoke ? If yes, how much/often : No Occasional 1/2 pack/day 1 pack/day 1+ pack
- Smoking Status
-
- Method of Tobacco Intake : Smoking Chewing
- Do you use Illegal Drugs : Yes No
- Hobbies/ Interests : _____