Overlake EyeCare, PS

Patient History Form

PATIENT NAME: DOB

RFV

1. Your reason for visiting our office today? (Check all that apply)

[ ] General/Routine check up	[ ] Broken/lost contact lenses	[ ] Eyes itch/painful/uncomfortable	[ ] Filmy vision
	[ ] Broken/lost glasses	[ ] Eyes red/swollen/tired	[ ] Flashes of light
[ ] Desire contact lenses	[ ] Eyes burn/dry/gritty	[ ] Eye strain	[ ] Floaters/spots in vision
[ ] Blurred distance vision	[ ] Eyes crossed/wander	[ ] Double vision	[ ] Light sensitivity
[ ] Blurred near vision	[ ] Eye discharge/mucus/water	[ ] Headaches/migraines	[ ] Night blindness

[ ] Other, please explain _____

Date of last eye examination _____ Age of present glasses _____ Age of present contacts _____

Have you worn contacts in the past? [ ] No [ ] Yes When? _____. Type? [ ] Soft [ ] Gas Perm [ ] Hard

Do you work on a computer? [ ] No [ ] Yes Hours per day? _____.

Do you have special visual needs? [ ] No [ ] Yes Please list type of special activity? _____

ROS

2. Have you had or are you being treated for any of the following conditions? (Check all that apply)

Recent weight loss or fever.	[ ] No	[ ] Yes	Details? _____
Ear, nose, mouth or throat disease.	[ ] No	[ ] Yes	Details? _____
Neurologic disease.	[ ] No	[ ] Yes	Details? _____
Psychiatric condition.	[ ] No	[ ] Yes	Details? _____
High blood pressure, heart or vascular disease.	[ ] No	[ ] Yes	Details? _____
Lung or respiratory disease.	[ ] No	[ ] Yes	Details? _____
Stomach or gastrointestinal disease.	[ ] No	[ ] Yes	Details? _____
Urinary or kidney disease.	[ ] No	[ ] Yes	Details? _____
Arthritis or musculoskeletal disease.	[ ] No	[ ] Yes	Details? _____
Rosacea or skin disease.	[ ] No	[ ] Yes	Details? _____
Thyroid or endocrine disease.	[ ] No	[ ] Yes	Details? _____
Blood or lymph disease.	[ ] No	[ ] Yes	Details? _____
Environmental allergies.	[ ] No	[ ] Yes	Details? _____

MEDS

3. Are you currently taking medication? [ ] No [ ] Yes Please list. _____

_____

_____

_____

_____

ALL

4. Are you allergic to any medication? [ ] No [ ] Yes Please list. _____

_____

PFSH

5. Have you had any eye surgery? [ ] No [ ] Yes Please list. _____

Have you had any eye disease? [ ] No [ ] Yes Please list. _____

Do any of your blood relatives have any of the following medical or ocular conditions? (Check all that apply)

[ ] Hypertension [ ] Diabetes [ ] Cancer [ ] Thyroid disease [ ] Macular degeneration

[ ] Glaucoma [ ] Cataracts [ ] Lazy eye [ ] Very poor eye sight

Do you drink alcohol? [ ] No [ ] Yes If yes [ ] Occasional [ ] Daily How much _____

Do you smoke? [ ] Never smoked [ ] Former smoker [ ] Current smoker How much _____

What is your height? _____ What is your weight? _____