**PATIENT NAME:**_____
**DOB:** _____

**PATIENT HISTORY**
**VISUAL HISTORY:**

| | YES | NO |
|---|---|---|
| Blurred Vision | □ | □ |
| Loss of Vision . . . . . | □ | □ |
| Double Vision . . . . . | □ | □ |
| Redness . . . . . | □ | □ |
| Dryness . . . . . | □ | □ |
| Itching . . . . . | □ | □ |
| Burning . . . . . | □ | □ |
| Eye Pain . . . . . | □ | □ |
| Tearing or Discharge . . . . . | □ | □ |
| Light Sensitivity or Glare . . . | □ | □ |
| Flashes or Floaters . . . . . | □ | □ |
| Loss of side vision . . . . . | □ | □ |
| Eye surgery or injury . . . . . | □ | □ |
| Lazy or crossed eye . . . . . | □ | □ |
| Glaucoma . . . . . | □ | □ |
| Cataracts . . . . . | □ | □ |
| Macular Degeneration . . . . . | □ | □ |
| Retinal Disease or Detachment . . | □ | □ |

**FAMILY HISTORY:**
DO ANY FAMILY MEMBERS HAVE THE FOLLOWING?:

| | YES | NO |
|---|---|---|
| Glaucoma . . . . . | □ | □ |
| Retinal Disease/Detachment . . . | □ | □ |
| Macular Degeneration . . . . | □ | □ |
| Lazy or Crossed Eye. . . . . | □ | □ |
| Blindness . . . . . | □ | □ |
| High Blood Pressure . . . . . | □ | □ |
| Diabetes . . . . . | □ | □ |

Other: _____
Do you currently wear contacts? _____
If yes, are they daily/monthly/monovision/multifocal (circle one)

Do you currently wear glasses? _____
If yes, do you wear SV, BF, TF, Progressives? (circle one)

| **SOCIAL HISTORY:** | YES | NO |
|---|---|---|
| | □ | □ |
| Are you pregnant or nursing? . . | □ | □ |
| Do you drive? . . . . . | □ | □ |
| Do you use tobacco products? | □ | □ |
| Do you use alcohol? . . . . . | □ | □ |
| Do you use drugs? . . . . . | □ | □ |

List any medications you currently take (prescription and over the counter) _____
_____

List allergies to any medications: _____
_____

List surgeries/hospitalizations you have had: _____
_____

**REVIEW OF SYSTEMS:** Please mark your health history below.

CONSTITUTIONAL none_____
___ headaches
___ weight loss
___ fever
___ fatigue

EAR, NOSE, MOUTH, THROAT none_____
___ upper respiratory
___ sinus

CARDIOVASCULAR none_____
___ heart disease
___ hypertension
___ stroke
___ vascular disease

RESPIRATORY none_____
___ smoker
___ bronchitis
___ asthma
___ emphysema

GASTROINTESTINAL none_____
___ Crohn's
___ colitis
___ ulcer

GENITOURINARY none_____
___ urinary tract infection
___ std
___ kidney

MUSCULOSKELETAL none_____
___ fibromyalgia
___ muscular dystrophy
___ osteoarthritis
___ ankylosing spondylitis

INTEGUMENTARY(skin) none_____
___ eczema
___ rosacea
___ psoriasis

NEUROLOGICAL none_____
___ multiple sclerosis
___ epilepsy

PSYCHIATRIC none_____
___ depression

ENDOCRINE
___ non-insulin dependent diabetes
___ insulin dependent diabetes
___ thyroid dysfunction
___ hormone dysfunction

HEMATOLOGICAL none_____
___ anemia
___ leukemia

ALLERGIC/IMMUNE none_____
___ rheumatoid arthritis
___ HIV
___ environmental allergies
___ to what?/what happens?_____
_____
_____

OTHER none_____
___ ADD
___ ADHD
___ Autism
___ Asperger's

CURRENT HEIGHT & WEIGHT (required by insurance companies as of 2012)
height _____ weight _____

_____ _____ _____
Patient Signature Doctor Signature Date