PATIENT HEALTH HISTORY

Thank you for choosing our practice. To better serve you, please fill out the information below to the best of your ability.

Today's Date____/____/____

Patient Name_____ Sex_____ Date of Birth____/____/____

Social Security # _____ Email Address _____

Home Address_____ City_____ State_____

Zip _____ **Cell Phone #** (_____)_____ Home Phone #(_____)_____

Occupation _____ Employer _____

Primary Care Physician_____

How did you learn of our practice?_____

Emergency Contact Name_____ Phone #(_____)_____Relation_____

EYE HISTORY

(check all that apply)

Do you currently wear? __glasses __contact lenses __neither

Are you using any prescription or non-prescription medication for your eyes? __ no __yes

If yes, please list _____

Have you ever had eye surgery? __no __yes

If yes please describe:

__ Right Eye: Type of Surgery_____Date____/____/____
Type of Surgery_____Date____/____/____

__ Left Eye: Type of Surgery_____Date____/____/____
Type of Surgery_____Date____/____/____

Have you ever injured your eye? __no __yes If yes, please describe:_____

Have you ever had any of the following eye conditions?

Glaucoma	__no __yes __ currently	Halos	__no __yes __ currently
Macular Degeneration	__no __yes __ currently	Light Sensitivity	__no __yes __ currently
Cataracts	__no __yes __ currently	Redness	__no __yes __ currently
Retinal Tear or Detachment	__no __yes __ currently	Itching	__no __yes __ currently
Lazy Eye/ Wandering Eye	__no __yes __ currently	Burning	__no __yes __ currently
Eye Pain	__no __yes __ currently	Dryness	__no __yes __ currently
Blurred Vision	__no __yes __ currently	Sandy/gritty sensation	__no __yes __ currently
Decreased Vision	__no __yes __ currently	Foreign Body Sensation	__no __yes __ currently
Double Vision	__no __yes __ currently	Discharge	__no __yes __ currently
Flashes of Light in Eyes	__no __yes __ currently	Crusting on Eyelid	__no __yes __ currently
Floating Dark Spots in Eyes	__no __yes __ currently	Drooping Eyelid	__no __yes __ currently

MEDICAL HISTORY

Are you currently being treated for any of the following?

__High Blood Pressure __Diabetes __Heart Disease __Stroke __Arthritis __Other_____

Have you ever been treated for a serious illness or medical conditions? ___no ___yes

If yes, please explain _____

_____

Have you had any hospitalization or surgery? ___no ___yes If yes, please explain_____

_____

Please list any medications that you take, prescription or non-prescription_____

_____

_____

Do you have drug allergies? ___no ___yes If yes, please list _____

SOCIAL HISTORY

Use of alcohol __never __rarely __moderate __daily

Use of tobacco __never __previously, but not since ___/___/___

__yes ___ packs/day

FAMILY MEDICAL HISTORY

	Age	Eye Disease
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
	_____	_____
Children	_____	_____
	_____	_____
	_____	_____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status.

Patient Signature_____ Date_____

(or guardian, if minor) _____