

PATIENT HISTORY FORM
SYSTEMIC HEALTH HISTORY

Please check any of the following conditions by which you or any member of your family has ever been affected:

- | | | |
|--------------------------|--------------------------|--|
| SELF | FAMILY | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes, childhood onset |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes, adult onset |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes, adult onset, suspect or borderline |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes, gestational |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension (High Blood Pressure), on meds |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension (High Blood Pressure), suspect or borderline |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Please list type: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Myesthenia Gravis |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic Disorder, Rhinitis (Nasal Allergies) |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic Disorder, Other (ie. Skin sensitivities) |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic Disorder, History of Anaphylaxis (ie, systemic reaction or stopped breathing after insect bite, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma, Mild (occasional inhaler) |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma, Moderate or Severe (daily meds or history of hospitalization for attacks) |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraine Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Other, Please describe: |

Please list any systemic medications that you are currently taking (including birth control, vitamins, homeopathic medications, hormones, and over-the-counter medications). If you have an extensive list of medications, we would be happy to photocopy it for you:

Please list any systemic/general surgeries which you have undergone:

ALLERGIC SENSITIVITIES TO MEDICATIONS [Review Of Systems: Allergic]

- I have no known allergic sensitivity to any systemic, ocular (eye), or over-the counter medications (NKMA).
- I have had allergic sensitivities to the following medications, (please list medication and describe reaction):

SOCIAL HISTORY

As with any of your personal health information, answers to the following questions will be kept confidential by both doctors and staff.

Do you smoke tobacco?

- No, I have never smoked tobacco regularly.
- I am a former smoker. I quit smoking (please choose one):
 - within the last year
 - 1-5 years ago
 - 6-10 years ago
 - more than 10 years ago
- I am a current smoker. How much do you smoke? (please choose one)
 - Less than 1/2 pack per day (light)
 - 1/2 - 1 pack per day (average)
 - More than 1 pack per day (heavy)

Do you consume alcohol?

- No, I never or rarely drink alcohol.
- Yes, I drink socially or occasionally.
- Yes, I drink 1-2 drinks per day.
- Yes, I have an alcohol dependency.

Do you consume narcotic substances, such as marijuana or cocaine?

- No, I never consume narcotic substances.
- Yes, I occasionally use marijuana.
- Yes, I have a chemical dependency.

Do you have any history of sexually transmitted disease, such as HIV?

- Yes.
- No.

Patient's Name (print):		Date of service (DOS):	
Date of birth (DOB):	Age:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
		<input type="checkbox"/> New	<input type="checkbox"/> Established

OCULAR (EYE) HEALTH HISTORY

Please check any of the following vision or eye health conditions by which you or any member of your family has ever been affected:

- | SELF | FAMILY | | SELF | FAMILY | |
|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Myopia, (Near-sighted) | <input type="checkbox"/> | <input type="checkbox"/> | Vitreous Floaters |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperopia (Far-sighted) | <input type="checkbox"/> | <input type="checkbox"/> | Vitreous Detachment |
| <input type="checkbox"/> | <input type="checkbox"/> | Astigmatism | <input type="checkbox"/> | <input type="checkbox"/> | Age-Related Macular Degeneration |
| <input type="checkbox"/> | <input type="checkbox"/> | Presbyopia (Near Blur After Age 40) | <input type="checkbox"/> | <input type="checkbox"/> | Lattice Degeneration |
| <input type="checkbox"/> | <input type="checkbox"/> | Amblyopia (Lazy Eye) | <input type="checkbox"/> | <input type="checkbox"/> | Retinal Detachment |
| <input type="checkbox"/> | <input type="checkbox"/> | Strabismus (Turned Eye) | <input type="checkbox"/> | <input type="checkbox"/> | Diabetic Retinopathy |
| <input type="checkbox"/> | <input type="checkbox"/> | Blepharoptosis (Droopy Eyelids) | <input type="checkbox"/> | <input type="checkbox"/> | Retinal Disorder, Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyelid Lesion (Bump) | <input type="checkbox"/> | <input type="checkbox"/> | Eye Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyelid Neoplasm (Cancerous Bump) | <input type="checkbox"/> | <input type="checkbox"/> | Eye Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry Eye Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | Head Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Keratoconus | <input type="checkbox"/> | <input type="checkbox"/> | Blindness |
| <input type="checkbox"/> | <input type="checkbox"/> | Corneal Scar | <input type="checkbox"/> | <input type="checkbox"/> | Other, please describe: |
| <input type="checkbox"/> | <input type="checkbox"/> | Cataracts | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | | | |

Please list any ocular (eye) medications that you are currently taking:

Please list any ocular (eye) or head/neck surgeries which you have undergone:

EYEGLOSS HISTORY:

The following describes my use of eyeglasses:

- I have never worn eyeglasses.
- I wore eyeglasses in the past.
- I wear eyeglasses full time.
- I wear eyeglasses as needed, (please choose one):
 - For distance vision primarily.
 - For reading (near) vision primarily.
 - I wear contacts primarily.

I last replaced my eyeglasses:

- Recently
- At my last exam
- Two or more exams ago

I need to replace my glasses today because they are:

- Lost
- Broken
- Scratched
- Uncomfortable to wear

Describe any difficulties that you have had with your past eyeglasses:

CONTACT LENS HISTORY:

The following describes my contact lens past history:

- I have never worn contact lenses previously.
- I have worn contact lenses previously. I last wore my contact lenses (please choose one):
 - Today/recently
 - 6 months ago
 - 1 year ago
 - 2 years ago
 - Many years ago

What type of contact lenses have you worn? Check any that apply.

- Soft, Conventional (replaced yearly)
- Soft, Disposable (replaced weekly to monthly)
- Soft, Toric (astigmatism correcting)
- Soft, Bifocal or Monovision (corrected near blur after age 40)
- Soft, Colored
- Hard or Rigid Gas Permeable (RGP)
- Hard or RGP, Bifocal or Monovision (corrected near blur after age 40)

Do you or did you ever sleep in your contact lenses overnight?

- Never or rarely [daily wear]
- Occasionally (1-2 nights per week or less) [flexible wear]
- Regularly (3 nights or more per week) [extended wear]

Do you wish to wear contact lenses again?

- Yes
- No

Describe any difficulties that you had with your past contact lenses, such as dryness:

Patient or guardian signature _____

Date _____