

Mr / Mrs / Ms / Dr

**Patient History Form**

Today's Date \_\_\_ / \_\_\_ / \_\_\_

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_

Email: \_\_\_\_\_ Referred by/Heard about us from: \_\_\_\_\_

**Insurance Information**

Name of **VISION** Plan: \_\_\_\_\_ Name of **MEDICAL** Plan: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Relationship to Insured:  Self  Spouse  Dependent

Relationship to Insured:  Self  Spouse  Dependent

Policy Holder's ID or SS#: \_\_\_\_\_ Policy Holder's ID or SS#: \_\_\_\_\_

**Medical Conditions/Review of Systems:** Do YOU currently have or have YOU ever had any problems in the following areas?

**Circle all that apply:**

CONSTITUTIONAL

Fever, Weight Loss, other

RESPIRATORY

Asthma, Emphysema, COPD, other

BONES/JOINTS/MUSCLES

Rheumatoid Arthritis, Fibromyalgia, other

INTEGUMENTARY (skin)

Herpes zoster/shingles, Rosacea, other

CARDIOVASCULAR

Hypertension, Stroke, Heart Disease, other

HEMOTOLOGIC/LYMPHATIC

Leukemia, Anemia, Bleeding, other

NEUROLOGICAL

Headache, Migraines, Seizures, MS, other

GASTROINTESTINAL

Crohns, Ulcer, other

ALLERGIC/IMMUNOLOGIC

Allergies, Autoimmune Disease, other

ENDOCRINE

Diabetes, Thyroid, other

GENITOURINARY

Kidney, Bladder, other

PSYCHIATRIC

Anxiety, Depression

List any **medications** you take (including eye drops, over-the-counter medicines, and/or supplements):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies to medications: Y N If yes, explain \_\_\_\_\_

**Ocular Review of Systems:** Do YOU currently have or have YOU ever had?

**Contact Lens Questions:**

Blurred Vision	Y	N	Eye Infections	Y	N
Dry Eyes	Y	N	Cataracts	Y	N
Itchy Eyes	Y	N	Glaucoma	Y	N
Eye Discharge	Y	N	Macular Degeneration	Y	N
Tearing	Y	N	Retinal Detachments	Y	N
Floating Spots	Y	N	Lazy Eye	Y	N
Flashing Lights	Y	N	Eye Surgery	Y	N

Are you interested in Contact Lenses?	Y	N
Have you ever worn contacts?	Y	N
Do you now wear contacts?	Y	N
What type?	_____	
How long have you had this pair?	_____	
Do you sleep in your contacts?	Y	N
Are you happy with your current lenses?	Y	N
Do your eyes feel irritated with contacts?	Y	N
Are you interested in trying a new lens?	Y	N
Are you interested in Laser Eye Surgery?	Y	N

Please give details for all "yes" \_\_\_\_\_

**Family History:** Please note any family members (parents, grandparents, siblings, children) with any of these conditions

Blindness	Y	N	Who: _____	Macular Degeneration	Y	N	Who: _____
Glaucoma	Y	N	Who: _____	Retinal Detachment	Y	N	Who: _____
Cataracts	Y	N	Who: _____	High Blood Pressure	Y	N	Who: _____
Diabetes	Y	N	Who: _____	Cancer	Y	N	Who: _____