

# Patient Health History

Please be certain to answer the following questions completely so that we are able to expedite your exam.

Patient Name \_\_\_\_\_  
(Last) (First) (Middle)

## YOUR VISION INFORMATION

Do you currently have any problems with the following, **please mark yes or no for all items:**

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Blurred Vision Near	<input type="checkbox"/>	<input type="checkbox"/>	Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision Distance	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tears or Watering	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>
Glare or Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infections	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	Please list w/dates _____		
Eye Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Please list w/dates _____		
Other Eye Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Please list w/dates _____		
Do you wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	Would you like to update your lenses and/or frame today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear contacts	<input type="checkbox"/>	<input type="checkbox"/>	If no, are you interested in contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## PERSONAL MEDICAL HISTORY

Are you currently experiencing or have you been diagnosed with any of the following, **please mark yes or no for all items:**

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
<b><u>GENERAL</u></b>			<b><u>RESPIRATORY</u></b>		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>NERVOUS SYSTEM</u></b>			Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>ENDOCRINE</u></b>		
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Please circle one: Type I or Type II		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Other glands	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>EAR, NOSE, THROAT</u></b>			Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>BONES/JOINTS/MUSCLES</u></b>		
Chronic Infections	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>GENITOURINARY</u></b>		
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>INTEGUMENTARY</u></b>			<b><u>CARDIOVASCULAR</u></b>		
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>GASTROINTESTINAL</u></b>			High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>ALLERGIC/IMMUNOLOGIC</u></b>		
<b><u>LYMPHATIC/HEMATOLOGIC</u></b>			Allergies - General	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Allergies - Medications	<input type="checkbox"/>	<input type="checkbox"/>

If you answered **YES** to any of the above or have a condition not listed, please explain. \_\_\_\_\_

Please list your current medications including eye drops. If you have a list of them and would like us to copy it, please let us know.

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