Patient Health History

Name _____

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

How is your general health? ❒ Poor ❒ Fair ❒ Good ❒ Excellent
Are you a current smoker? ❒ Yes ❒ No ❒ Prefer not to answer
Who is your family physician? _____ Date of last visit _____

Your Vision Information

	Yes	No	
Eye Surgeries	❒	❒	Please list w/dates _____
Eye Injuries	❒	❒	Please list w/dates _____
Other Eye Conditions	❒	❒	Please list w/dates _____
Do you wear glasses	❒	❒	Would you like to update your lenses and/or frame today? ❒ Yes ❒ No
Do you wear contacts	❒	❒	If no, are you interested in contact lenses? ❒ Yes ❒ No

Aside from new glasses or contacts, what is the primary reason for your visit today? _____

_____

_____

_____

_____

_____

Personal Medical History

Are you currently being treated for **OR** have you been diagnosed with any of the following,

Please mark yes or no for all items:

	Yes	No
ALLERGIC/IMMUNOLOGIC		
Allergies - General	❒	❒
Allergies to Medications	❒	❒
BONES/JOINTS/MUSCLES		
Arthritis	❒	❒
Joint Pain	❒	❒
CARDIOVASCULAR		
Heart Pain	❒	❒
High Blood Pressure	❒	❒
Vascular Disease	❒	❒
EAR, NOSE, THROAT		
Chronic Infections	❒	❒
Chronic Cough	❒	❒
Dry Throat/Mouth	❒	❒
ENDOCRINE		
Diabetes	❒	❒
Please circle one: Type I or Type II		
Thyroid/Other glands	❒	❒
Elevated Cholesterol	❒	❒
GASTROINTESTINAL	❒	❒
GENITOURINARY		
Kidney/Bladder problems	❒	❒
INTEGUMENTARY		
Skin problems	❒	❒
LYMPHATIC/HEMATOLOGIC		
Anemia	❒	❒
NERVOUS SYSTEM		
Headaches	❒	❒
Migraines	❒	❒
Seizures	❒	❒
Stroke	❒	❒
RESPIRATORY		
Asthma	❒	❒
Chronic Bronchitis	❒	❒
COPD	❒	❒
Emphysema	❒	❒

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.

_____ _____ _____

_____ _____ _____

_____ _____ _____