Health History

Patient Name:	Date of Birth:	Social Security #:

Address:

Phone: Circle Preferred: (H) (W) (C)

Email:

would you like to receive text messages? Yes / No

Primary Care Physician:

Race (Please Select One): American Indian or Alaskan Native Black or African American Hispanic Asian Native Hawaiian or Pacific Islander White Other Decline

Health Insurance:

Hispanic or Latino? Yes No Decline

Vision Insurance: **Employer:** **Occupation:**

Main Reason for Visit:

Referred by:

Are you interested in contact lenses? Yes No

Are you having any of the following vision concerns?		
Blurred vision with current prescription?	Yes	No
Eyestrain?	Yes	No
Eye Pain?	Yes	No
Severe sensitivity to light and / or night glare?	Yes	No
Headache?	Yes	No
Poor night vision or glare?	Yes	No
Double vision?	Yes	No
Any additional concerns?		

Are you having any of the following eye concerns?		
Redness?	Yes	No
Burning?	Yes	No
Itching?	Yes	No
Tearing?	Yes	No
Discharge?	Yes	No
Any additional concerns?		

Alcohol Use: Never Rarely Moderately Daily

Tobacco Use Never Yes Previous

Past Ocular History (Self)		
Cataract	Yes	No
Age-Related Macular Degeneration	Yes	No
Glaucoma	Yes	No
Diabetes	Yes	No
Diabetic Retinopathy	Yes	No
Dry Eye	Yes	No
Eye infection, inflammation, or allergy	Yes	No
Floaters and/or flashes of light	Yes	No
Iritis or Uveitis	Yes	No
Retina defects or Degenerations	Yes	No

Other:

Drug and / or Enviromental Allergies?

Family Medical History			
Hypothyroidism	Yes	No	Father Mother Brother Sister Son Daughter
Hyperthyroidism	Yes	No	Father Mother Brother Sister Son Daughter
Cancer	Yes	No	Father Mother Brother Sister Son Daughter
Diabetes	Yes	No	Father Mother Brother Sister Son Daughter
Hypertension	Yes	No	Father Mother Brother Sister Son Daughter
Other:			

Family Ocular History			
Dry Eye	Yes	No	Father Mother Brother Sister Son Daughter
Macular Degeneration	Yes	No	Father Mother Brother Sister Son Daughter
Strabismus	Yes	No	Father Mother Brother Sister Son Daughter
Retinal Detachment	Yes	No	Father Mother Brother Sister Son Daughter
Amblyopia	Yes	No	Father Mother Brother Sister Son Daughter
Cataract	Yes	No	Father Mother Brother Sister Son Daughter
Glaucoma Suspect	Yes	No	Father Mother Brother Sister Son Daughter
Glaucoma	Yes	No	Father Mother Brother Sister Son Daughter
Other:			