

## HEALTH HISTORY

**Welcome to our Practice. As a new patient, please fill out the information found below to the best of your ability.**

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Patient # \_\_\_\_\_

SSN \_\_\_\_\_  Male  Female Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

### Eye History

Have you ever had the following eye conditions? (Circle "no" or "yes", leave blank if uncertain)

Glaucoma, Cataracts, Etc	No	Yes	Flashes or Floaters	No	Yes
Loss of Vision	No	Yes	Sandy or Gritty	No	Yes
Blurred Vision	No	Yes	Burning	No	Yes
Fluctuating Vision	No	Yes	Itching	No	Yes
Distorted Vision	No	Yes	Foreign Body Sensation	No	Yes
Loss of Side Vision	No	Yes	Glare/Light Sensitivity	No	Yes
Double Vision	No	Yes	Pain or Soreness	No	Yes
Dryness	No	Yes	Infection	No	Yes
Mucous Discharge	No	Yes	Tired Eyes	No	Yes
Redness	No	Yes	Drooping Eyelid	No	Yes
Lazy Eye/Crossed Eye	No	Yes	Excess Tearing	No	Yes

## MEDICAL INFORMATION

What is your general health? \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_ When was your last physical? \_\_\_\_\_

Do you have problems with any of these systems? (please circle all that apply)

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (Glands)	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/Lymph	Y/N
				Allergic/immunologic	Y/N

Please explain: \_\_\_\_\_

Please answer all that apply:

Diabetes Y/N Type \_\_\_\_\_ Date of diagnosis \_\_\_\_\_

Allergies Y/N Allergic to what? \_\_\_\_\_ What happens? \_\_\_\_\_

Medication allergy Y/N What happens? \_\_\_\_\_

Other health problems \_\_\_\_\_

**Medications:** \_\_\_\_\_

(Include Non-Prescription) \_\_\_\_\_

**Patient Social History:** (circle appropriate answer)

Use of Alcohol: Never Rarely Moderate Daily

Use of Tobacco: Never Previously, but not in the past \_\_\_\_\_ year(s) Current packs/day: \_\_\_\_\_

Do you have visual difficulty when driving? Yes No

Do you currently wear: Contact Lenses Glasses Neither

### Family Medical History:

	Age	Medical/Eye Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____