Patient History Form

Name:_____ Date:_____

Address:_____

Best phone number:_____ (Home or Cell) Ok to text: □ No □ Yes

Second best number:_____ (Home or Cell) Email:_____

Employer / Occupation:_____ DOB:_____

Reason for Visit:_____

1. Do you have? (please check all that apply)

□ eyestrain □ dry eyes □ floaters □ itchy eyes □ flashes of light □ double vision

□ blurred vision with or without glasses/contacts □ severe or frequent headaches

□ frequent neck and shoulder pain

2. Who is your primary physician:_____Date of last physical:_____

3. Do you wear glasses: □ No □ Yes Age of current glasses: _____ Last eye exam:_____

4. Do you wear contact lenses: □ No □ Yes Brand of contacts:_____Prescription: _____

If you are not a contact lens wearer, would you like a contact lens evaluation: □ No □ Yes

5. Have your eyes ever been dilated before? □ No □ Yes

6. Do you or any blood relatives (siblings, parents, grandparents, children) have? (please check all that apply)

	Self	Blood Relative		Self	Blood Relative
retinal/macular dis.	□	□	high blood pressure	□	□
cataracts	□	□	thyroid problems	□	□
glaucoma	□	□	asthma	□	□
diabetes	□	□	lung disease	□	□
high cholesterol	□	□	heart disease	□	□

7. Are you pregnant? (if applicable) □ No □ Yes

8. Are you being treated for any medical conditions? □ No □ Yes

9. Circle one; if you smoke / drink / recreational drugs? (if yes, how often?)_____

10. Are you taking any medications? □ No □ Yes

if yes, please list:_____

11. Are you allergic to any medications? □ No □ Yes

if yes, please list:_____

12. Do you have or have ever had any eye disease, injury, or surgery? □ No □ Yes

if yes, please list:_____

Patient Verification

The patient history that I have provided is true and complete to the best of my knowledge.	Signature (if under 18 years of age, parent signature is required)	Date: