PATIENT HISTORY

Date: / /

Name Mr. Mrs. Ms._____Date of Birth / /

Address: _____City_____State_____Zip_____

Phone: Home_____Cell _____Work_____Last 4 of SS#_____

Email:_____Referred by_____

Occupation_____Vision Insurance_____Health Ins_____

Are you presently wearing glasses? Y N Full time____Part time___
Are you presently wearing contact lenses? Y N Soft_____ Hard/Gas Permeable_____

Date of your last visual examination_____Date of your last physical examination_____

Are you having any of the following problems?

Headaches	Y N	Distance blur	Y N	Vertigo	Y N
Migraines	Y N	Near (close) blur	Y N	Itchy/watery eyes	Y N
Floaters/flashes	Y N	Computer strain	Y N	Sleep disorders	Y N

Are you presently taking any medications, including over the counter medications? Y N

If yes, please list them_____

Is there a family history of high blood pressure? Who? _____ Y N

Is there a family history of diabetes? Who?_____ Y N

Is there a family history of glaucoma or retinal disease? Who?_____Y N

Do you have any allergies, including medications? If Yes, please list_____ Y N

Have you been treated for any eye diseases? Outcome?_____ Y N

Have you had any ocular surgery, including refractive surgery? Notes:_____ Y N

Do you smoke? Y N ____Packs/Day Do you drink alcoholic beverages? Y N _____Drinks/Day

Are you presently in good health? Y N
If under the care of a physician for chronic health problems, please list them:

_____

Do you wear sun protection for your eyes? Y N

List hobbies, outdoor activities: _____

Signature for insurance filing: _____