

# Patient Health History

Name \_\_\_\_\_ Date \_\_\_\_\_

This thorough medical history will help us provide you with better eye health care since many aspects of your overall health can affect your eye health. All information is confidential. Thank you for your cooperation!

## General History

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What is the main reason for your visit today? \_\_\_\_\_

Last eye exam: \_\_\_\_\_

How often do you wear glasses? \_\_\_\_\_

How often do you wear sunglasses? \_\_\_\_\_

Do you use eye drops ? (please list type and dose) \_\_\_\_\_  
\_\_\_\_\_

Average time per day spent on computer \_\_\_\_\_

Any eye infections or injuries? \_\_\_\_\_

Have you had eye surgery or laser treatment to your eyes. (please list)  
\_\_\_\_\_  
\_\_\_\_\_

Are you interested in:

Refractive surgery? Y N

Contact lenses? Y N

Have you had a blood transfusion? Y N

Do you have a history of drug use? Y N

Do you smoke? Y N

Average packs per day: \_\_\_\_\_

Average number of alcoholic beverages per day  
\_\_\_\_\_

## Contact Lens History

Average contact lens wearing time: \_\_\_\_\_ Lens wearing time today: \_\_\_\_\_

Brand and age of current lenses: \_\_\_\_\_ Disinfecting system: \_\_\_\_\_

Do you sleep in your lenses? Yes No If so, how often? \_\_\_\_\_

Rate the following: Overall lens comfort: Excellent Fair Poor

Distance vision: Excellent Fair Poor

Near vision: Excellent Fair Poor

List any specific visual requirements relating to your occupation, sports activities, and hobbies.  
\_\_\_\_\_  
\_\_\_\_\_

## Physician, Allergies, and Medications

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Personal Physician \_\_\_\_\_ Physician's phone # \_\_\_\_\_

Name and Location of Clinic \_\_\_\_\_

Please list any allergies: Medication \_\_\_\_\_ Food \_\_\_\_\_ Seasonal \_\_\_\_\_ Chronic \_\_\_\_\_

Have you ever fainted or lost consciousness? \_\_\_\_\_

In the space to the right, please list any medications and/or vitamins/herbs you are currently taking, time you have been taking it, and its purpose.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Continued on reverse side)

## Systemic History

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Do you have problems in the following areas? *(Please describe)*

**Yes**    **No**    **Endocrine**  
        Goiter \_\_\_\_\_  
        Hyperthyroid \_\_\_\_\_  
        Graves' Disease \_\_\_\_\_  
        Hypothyroid \_\_\_\_\_  
        Cushing's Disease \_\_\_\_\_

**Yes**    **No**    **Cardiovascular/Blood**  
        Heart disease \_\_\_\_\_  
        Stroke \_\_\_\_\_  
        High blood pressure \_\_\_\_\_  
        Diabetes \_\_\_\_\_  
        Anemia \_\_\_\_\_  
        Arrhythmia \_\_\_\_\_  
        Elevated Cholesterol/Triglycerides \_\_\_\_\_

**Yes**    **No**    **Neurological**  
        Seizures \_\_\_\_\_  
        Migraines/Headaches \_\_\_\_\_  
        Multiple Sclerosis \_\_\_\_\_  
        Bad Fall/Head Trauma \_\_\_\_\_

**Yes**    **No**    **Gastrointestinal/Genitourinary**  
        Stomach \_\_\_\_\_  
        Intestines/Colon \_\_\_\_\_  
        Genitals \_\_\_\_\_  
        Kidneys \_\_\_\_\_  
        Bladder \_\_\_\_\_

**Yes**    **No**    **Musculoskeletal**  
        Muscle/Joint pain \_\_\_\_\_  
        Arthritis \_\_\_\_\_  
        Fibromyalgia \_\_\_\_\_

**Yes**    **No**    **Psychiatric**  
        Depression / Anxiety \_\_\_\_\_  
        Other \_\_\_\_\_

**Yes**    **No**    **Respiratory**  
        Chronic bronchitis \_\_\_\_\_  
        Asthma \_\_\_\_\_  
        Tuberculosis \_\_\_\_\_  
        Sinus/Post-Nasal \_\_\_\_\_

**Yes**    **No**    **Skin**  
        Acne Rosacea \_\_\_\_\_  
        Herpes Simplex/Zoster \_\_\_\_\_  
        Skin Cancer \_\_\_\_\_  
        Other \_\_\_\_\_

**Yes**    **No**    **Other Major Illnesses**  
        Cancer \_\_\_\_\_  
        Lupus \_\_\_\_\_  
        Sarcoidosis \_\_\_\_\_  
        Sjögren's Syndrome \_\_\_\_\_  
        Other \_\_\_\_\_

Please List any recent surgeries you may have had: \_\_\_\_\_  
\_\_\_\_\_

## Family History

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Please list siblings, parents, and/or grandparents diagnosed with any of the following:

Cataracts \_\_\_\_\_  
Glaucoma \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Macular Degeneration \_\_\_\_\_  
Blindness (any cause) \_\_\_\_\_  
Corneal Disease \_\_\_\_\_  
Retinal Detachment \_\_\_\_\_

Glasses/Vision Problems \_\_\_\_\_  
Other Eye Diseases \_\_\_\_\_  
Heart Disease/Heart Attack \_\_\_\_\_  
Cancer \_\_\_\_\_  
Stroke \_\_\_\_\_  
Autoimmune Disease \_\_\_\_\_  
Migraines \_\_\_\_\_

Patient Signature \_\_\_\_\_ Physician Signature \_\_\_\_\_ Date \_\_\_\_\_