Health History Form

E-mail

Today's Date

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PERSONAL INFORMATION

First Name

Last Name

MI

Home Phone

Cell Phone

Work Phone

Prefered Method of Contact

Phone Text Email

Mailing Address

City

State

Zip

Date of Birth

Sex

Social Security #

Employer

Occupation

Emergency Contact Name

Relationship To Patient

Emergency Contact Phone #

How did you hear about us?

If you are completing this form for another person, what is your relationship to that person?

Your Name

Relationship

Home Phone #

Cell Phone #

OPTICAL INFORMATION

Last Primary Care Visit

Primary Care Physician

Last Eye Exam

Previous Eye Doctor

List any previous surgeries with dates

For the following questions mark (x) your responses

	Yes	No
Do you wear glasses?	○	○
Do you wear contact lenses?	○	○

If so, which brand?

	Yes	No
Are you interested in contact lenses?	○	○

Ocular History *For the following questions mark (x) your responses*

	Yes	No		Yes	No
Age-related macular degeneration	○	○	Injury to the eye region	○	○
Amblyopia (Lazy eye)	○	○	Keratoconus	○	○
Blindness-one eye	○	○	Retinopathy	○	○
Bindness-both eyes	○	○	Strabismus (Crossed eyes)	○	○
Cataracts	○	○	Tear film insufficiency (dry eyes)	○	○
Glaucoma	○	○	Other		
History of refractive surgery	○	○			

Please list any family history of any eye disease

Reason for today's visit

MEDICAL INFORMATION

For the following questions, please mark (X) your responses.

Are you in good health?..... Yes ○ No ○

Has there been any change in your general health within the past year?..... Yes ○ No ○

If yes, what condition is being treated?

For the following questions mark (x) your responses

Do you use tobacco (smoking, snuff, chew, bidis)?..... Yes ○ No ○

Do you drink alcoholic beverages?..... Yes ○ No ○

WOMEN ONLY Are you:

Pregnant?..... Yes ○ No ○

Number of weeks

Taking birth control pills or hormonal replacements?..... Yes ○ No ○

Have you had a serious illness, operation or been hospitalized in the past 5 years?..... Yes ○ No ○

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... Yes ○ No ○

If yes, please list all medications, including vitamins, natural or herbal preparations and/or diet supplements:

Allergies: Please list any allergies

Please mark (X) your response if you have or have had any of the following diseases or problems.

Cardiovascular disease.... Yes ○ No ○

High blood pressure..... Yes ○ No ○

Anemia..... Yes ○ No ○

Autoimmune disease..... Yes ○ No ○

Rheumatoid arthritis..... Yes ○ No ○

Systematic lupus erythematosus..... Yes ○ No ○

Lung Disease..... Yes ○ No ○

Cancer/Chemotherapy/ Radiation treatment..... Yes ○ No ○

Diabetes type I or type II... Yes ○ No ○

If yes, last A1c

Gastrointestinal disease... Yes ○ No ○

Thyroid problems..... Yes ○ No ○

Stroke..... Yes ○ No ○

Epilepsy..... Yes ○ No ○

Neurological disorders..... Yes ○ No ○

If yes, please specify

Mental health disorders..... Yes ○ No ○

If yes, please specify

Fainting spells/seizures.... Yes ○ No ○

Severe headche/migraines.. Yes ○ No ○

Do you have any disease, condition, or problem not listed above that you think I should know about?..... Yes ○ No ○

If yes, please explain

PHARMACY INFORMATION

Pharmacy Name

Pharmacy Phone

Pharmacy Address

FOR COMPLETION BY OFFICE

Comments: