PATIENT HEALTH INFORMATION

Name	Date of Birth	Date of Exam
Address		
City, State, ZIP		

If a student: Grade:____ School Name:_____ City/State:_____

MEDICAL HISTORY

List medications you are currently taking (prescription, over-the-counter, and vitamins/supplements)

_____

Do you have any allergies to medications? Y N If yes, please list:

_____

List major illnesses, injuries, and surgeries you have had.

_____

Name and office location of your medical doctor(s)_____

Date of your last physical exam _____

Are you pregnant/nursing?_____

Name of previous eye doctor?		Have you ever had your pupils dilated?	Y N
Date of last eye exam:		If yes were there any problems?	Y N
Do you wear glasses?	Y N	Have you ever worn contact lenses?	Y N
If yes, when do you wear your glasses? _____		Do you now wear contact lenses?	Y N
If yes, how old are your glasses? _____		What type of lens? (circle)	
If yes, what type of glasses? (circle)		Hard/RGP Soft Extended Bifocal	
Single Vision Bifocal Trifocal Progressive			

FAMILY HISTORY Please note any family members with the following conditions.

CONDITION	YES	NO	UNSURE	RELATIONSHIP
Blindness				
Glaucoma				
Macular Degeneration				
Arthritis				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Other				

SOCIAL HISTORY

What is your occupation? _____

List your hobbies/recreational activities. _____

Does your occupation or any hobbies/recreational activities require the use of safety eyewear? Y N

Do you use a computer at work or at home?	Y N	Do you drink alcohol?	Y N
Approximate hours per day _____		If yes, how often? _____	
Do you drive?	Y N	Do you use illegal drugs?	Y N
If yes, do you have visual difficulty when driving?	Y N	Have you ever been exposed to HIV?	Y N
Do you use tobacco products?	Y N	Have you ever been exposed to TB?	Y N
If yes, what type/amount/how long?	Y N		

PLEASE COMPLETE THE REVERSE SIDE ALSO

REVIEW OF SYSTEMS Do you now have or have you ever had any of the following health conditions?

CONDITION	YES	NO	IF YES, PLEASE EXPLAIN
• Eyes			
• Eye injury, pain, or surgery			
• Loss of vision			
• Blurred vision			
• Tired eyes			
• Redness			
• Itching			
• Burning			
• Sandy or dry eyes			
• Excessive tears (watery eyes)			
• Vision disturbances (spots, halos, light flashes)			
• Light sensitivity/ glare			
• Double vision			
• Glaucoma			
• Cataract			
• Macular degeneration			
• Diabetic retinopathy			
• Amblyopia (lazy eye)			
• Eye turn (eso or exotropia)			
• Keratoconus			
• Learning disability			
• Constitutional (fever, weight loss)			
• Ears, Nose, Mouth, Throat (sinus, chronic cough, etc)			
• Respiratory (asthma, emphysema, etc.)			
• Cardiovascular (high blood pressure, vascular disease, heart disease, high cholesterol)			
• Gastrointestinal (diarrhea, constipation, ulcers, etc.)			
• Genitourinary (genitals, kidney, bladder)			
• Muscles/Bones/Joints (arthritis, etc.)			
• Endocrine (diabetes, thyroid, etc)			
• Psychiatric (anxiety, depression, etc)			
• Blood/Lymph (anemia, high cholesterol, etc)			
• Allergic/Immunologic (hay fever, lupus, etc.)			
• Skin			
• Neurological (headaches, multiple sclerosis, etc)			

Patient's Insurance Carrier _____ **Employer** _____

Spouse's Insurance Carrier _____ **Employer** _____

"I am responsible for payment at the time of each visit for all services provided not covered by an insurer. My signature serves as a "signature on file" for claim processing and for release of medical information to my insurance carrier (s)."

_____ _____

Signature of patient or person authorized to sign for patient Reviewed by: Maribeth Bangert, OD Date