



Please complete this **Health History Form** so we may better serve you. Thank you.

Name: _____ Today's date: _____

Name you preferred to be called: _____ Birth date: _____

Date of last Physical Exam: _____ Date of last Eye Exam: _____

REASON FOR VISIT

What is the **MAIN REASON** for your visit today?

SPECTACLE / CONTACT LENSES

Are you planning on getting new glasses? **YES** **NO**

How often do you wear glasses? Never Full-Time Part Time Distance only Reading only

Do you presently wear contact lenses? **NO** Full-Time Part Time

Would you like to see if you are a good candidate for the latest contact lens designs? **YES** **NO**

Would you like to discuss laser refractive surgery (LASIK) options today? **YES** **NO**

VISION NEEDS

What type of work you do? _____

What specific job related vision needs should we know about? _____

How much time do you spend on the computer? Work: _____ Hours/Day Home: _____ Hours/Day

Check any of the following symptoms that you experience while using your computer:

Tired eyes	Dry eyes	Headaches	Burning eyes
Blurred vision	Double Vision	Red eyes	Stinging eyes

Do you use special computer glasses? **YES** **NO**

Are you interested in designated glasses to make computer work easier? **YES** **NO**

SPORTS AND LEISURE

What sports, recreational activities, or hobbies do you participate in?

EYE / VISION PROBLEMS

Check all that apply.

NO Eye or Vision problems to report.

Blurred Vision	Eyelid: Lump/Bump	Glare	Eye Fatigue
Burning Eyes	Eyelid: Puffy/Swollen	Halos	Eye Pain
Double Vision	Recent flashes of light	Headache	Redness
Dry Eye	Recent Floaters	Itchy Eyes	Sandy/Gritty Feeling
Eyelid: Crusty / Sticky	Foreign Body Sensation	Light Sensitivity	Watery Eyes

Any other eye/vision problems not listed above? _____

MEDICAL HISTORY

NO Medical History to report.

AIDS/ HIV Positive	Me		Diabetes	Me	Family	Multiple sclerosis	Me	Family
Allergic disorders	Me	Family	Head trauma	Me		Pregnant:	No	Yes ____ Month
Arthritis	Me	Family	Heart disease	Me	Family	Respiratory disorder	Me	Family
Cancer	Me	Family	Hypertension	Me	Family	Stroke	Me	Family
Cholesterol, high	Me	Family	Migraines	Me	Family	Thyroid disease	Me	Family

Any other health problems? _____

SURGICAL HISTORY

List any major injuries or surgeries you have had.

EYE HISTORY

NO Eye History to report.

Amblyopia (lazy eye)	Me	Family	Macular Degeneration	Me	Family
Blindness	Me	Family	Retinal Detachment	Me	Family
Cataracts	Me	Family	Strabismus (eye turn)	Me	Family
Color Deficiency	Me	Family	Glaucoma	Me	Family

Any other eye/vision problems? _____

EYE SURGERY/ INJURY

List which eye, type of surgery or injury, and date.

EYE MEDICATIONS or EYE DROPS (Including over the counter)**MEDICATIONS**

NO Medications or Supplements Taken

Please list all current medications and supplements. (Including oral contraceptives, aspirin, and over the counter)

MEDICATION ALLERGY & EFFECTS

NO Known Medication Allergies.

SOCIAL HISTORY*Information strictly confidential.*

I would like to discuss this privately with my doctor.

Tobacco use

Alcohol use

Narcotic use

Sexually transmitted diseases

Other: _____

Signature _____ Date: _____