



**PATIENT HISTORY RECORD**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Personal Physician: \_\_\_\_\_

Occupation: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

What brings you in to see us today? \_\_\_\_\_

Date of last eye exam? \_\_\_\_\_ Previous Eye Physician: \_\_\_\_\_

Please answer the following questions about **your** medical status and history:

**Please circle any of the following that you are being treated for or have been treated for in the past:**

- |                     |                    |                       |
|---------------------|--------------------|-----------------------|
| Diabetes            | Strabismus         | Retinal Disease       |
| High blood pressure | Cataract           | Macular degeneration  |
| Tuberculosis        | Cancer             | Blindness             |
| Lupus               | Glaucoma           | Heart disease         |
| Amblyopia           | Serious eye injury | Arthritis /Rheumatoid |
| Other: _____        | Other: _____       |                       |

Have you ever had any eye surgery or other surgery?

No \_\_\_ If YES, Please explain: \_\_\_\_\_

Do you take **medications** or vitamin supplements?

No \_\_\_ If YES, Please complete attached medication form.

Do you take any **eye drops** or **medication for your eyes**?

No \_\_\_ If YES, Please list: \_\_\_\_\_

Do you have any drug or food allergies?

No \_\_\_ If YES, Please explain: \_\_\_\_\_

**Please circle any of the following problems that you are currently experiencing, or have experienced:**

- |                                 |                     |                                |
|---------------------------------|---------------------|--------------------------------|
| Vision changes: Gradual//Sudden | Irregular Heartbeat | Anxiety                        |
| Eye Irritation                  | Abdominal           | Allergies                      |
| Muscle aches                    | Skin rashes         | Heartburn                      |
| Joint Pain                      | Excessive dry skin  | Headaches                      |
| Fatigue                         | Weakness//Numbness  | Chronic fever                  |
| Hearing loss                    | Coughing/Wheezing   | Chest pain                     |
| Sinus Problems                  | Shortness of breath | Unexpected weight gain or loss |

**Has anyone in your family ever been diagnosed with any of the following? Please circle.**

Diabetes	Strabismus	Retinal Disease
High blood pressure	Cataract	Macular degeneration
Tuberculosis	Cancer	Blindness
Lupus	Glaucoma	Heart disease
Amblyopia	Serious eye injury	Arthritis/Rheumatoid
Other: _____	Other: _____	

Do you smoke? If Yes, how much? \_\_\_\_\_

Drink alcohol? If Yes, how much? \_\_\_\_\_

Do you wear glasses? If Yes: Reading or Distance No \_\_\_\_\_

Do you wear contact lenses? No: \_\_\_\_\_ Yes: \_\_\_\_\_

If Yes, which type? \_\_\_\_\_ Soft Lenses \_\_\_\_\_ Rigid gas permeable lenses \_\_\_\_\_ Hard lenses

**PLEASE BRING BRAND, BASE CURVE & DIAMETER AND PRESCRIPTION INFORMATION (SEE YOUR CONTACT LENS BOX) TO YOUR VISIT**

How often do you throw them away? \_\_\_\_\_

How many years have you worn contact lenses? \_\_\_\_\_

Do you sleep in your contacts? \_\_\_\_\_ No \_\_\_\_\_ Yes: How often? \_\_\_\_\_

Do you wish to be fit for contact lenses or renew your contact lens prescription? \_\_\_\_\_ No \_\_\_\_\_ Yes

**IMPORTANT:** For a **Contact Lens Fitting** or **Contact Lens Prescription Renewal**, there will be a fitting charge in addition to the standard examination fee that may or may not be covered by your insurance plan. Patient is responsible for any of these charges not covered by your insurance. These fees will be due at the time of service. Please speak to your insurance provider regarding complete details on this.

**Please be sure to bring your list of Medications, Glasses and/or Contact Lenses with you.**

**Please bring sunglasses with you, as your eyes will be dilated.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_