Mr / Mrs / Ms / Dr **Patient History Form** Today's Date ____ /____/_____

Patient Name: _____ Date of Birth ____/____/_____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (____) _____ E-mail: _____

Occupation: _____ Employer: _____ Last Eye Exam: _____

Do you have any allergies to medications: Y N If yes, explain_____

List any medications you take: _____

_____

Are you pregnant? Y N

Ocular Review of Systems: do you currently or have you ever had?

Blurred Vision	Y	N	Eye Infections	Y	N
Dry Eyes	Y	N	Cataracts	Y	N
Itchy Eyes	Y	N	Glaucoma	Y	N
Eye Discharge	Y	N	Macular Degeneration	Y	N
Tearing	Y	N	Retinal Detachments	Y	N
Floating Spots	Y	N	Lazy Eye	Y	N
Flashing Lights	Y	N	Eye Surgery	Y	N

Please give details for all "yes"_____
_____

Contact Lens Questions:

Are you interested in contact lenses?	Y	N
Have you ever worn contacts?	Y	N
Do you now wear contacts?	Y	N
What type? _____		
How long have you had this pair? _____		
How often do you sleep in your contacts? _____		
Are you happy with your current lenses?	Y	N
Do your eyes feel irritated with contacts?	Y	N
Are you interested in trying a new lens?	Y	N

Family History: Please note any family members (parents, grandparents, siblings, children) with any of these conditions

Blindness	Y	N	Who: _____	Macular Degeneration	Y	N	Who: _____
Glaucoma	Y	N	Who: _____	Retinal Detachment	Y	N	Who: _____
Cataracts	Y	N	Who: _____	High Blood Pressure	Y	N	Who: _____
Diabetes	Y	N	Who: _____	Cancer	Y	N	Who: _____

Social History: This information is kept strictly confidential. If you prefer, you may discuss this portion directly with the Doctor.

Do you drive?	Y	N	Do you use tobacco?	Y	N
Do you have difficulty driving?	Y	N	Do you use street drugs?	Y	N
Do you drink alcohol	Y	N	Have you ever been infected with:		
			____ HIV____ Hepatitis ___ Tuberculosis ___		

Review of Systems: Do you currently have or have you ever had any problems in the following areas? Circle all that apply

CONSTITUTIONAL
Fever, Weight Loss, other

RESPIRATORY
Asthma, Emphysema, COPD, other

BONES/JOINTS/MUSCLES
Rheumatoid Arthritis, Fibromyalgia, other

INTEGUMENTARY (skin)
Herpes zoster/shingles, Rosacea, other

CARDIOVASCULAR
Hypertension, Stroke, Heart Disease, other

HEMOTOLOGIC/LYMPHATIC
Leukemia, Anemia, Bleeding, other

NEUROLOGICAL
Headache, Migraines, Seizures, MS, other

GASTROINTESTINAL
Crohns, Ulcer, other

ALLERGIC/IMMUNOLOGIC
Allergies, Autoimmune Disease, other

ENDOCRINE
Diabetes, Thyroid, other

GENITOURINARY
Kidney, Bladder, other

PSYCHIATRIC
Anxiety, Depression