

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

Preferred Method of Contact
 Phone Text Email

Mailing Address City State Zip

Height Weight Date of Birth Sex

Occupation Emergency Contact

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		Yes	No
Do you wear glasses?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have trouble reading signs when driving at night?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you bothered by glare from: Overhead lighting?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>	A computer screen?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in refractive surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	Oncoming headlights at night?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you perform fine or close-up work?.....	<input type="checkbox"/>	<input type="checkbox"/>	Are your eyes sensitive in bright sunlight?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you outdoors all or part of the time?.....	<input type="checkbox"/>	<input type="checkbox"/>	How many hours per day do you use a computer?		

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

	Yes	No		Yes	No
Age-related macular degeneration.....	<input type="checkbox"/>	<input type="checkbox"/>	Injury to the eye region.....	<input type="checkbox"/>	<input type="checkbox"/>
Amblyopia (Lazy eye).....	<input type="checkbox"/>	<input type="checkbox"/>	Keratoconus.....	<input type="checkbox"/>	<input type="checkbox"/>
Blindness-one eye.....	<input type="checkbox"/>	<input type="checkbox"/>	Retinopathy.....	<input type="checkbox"/>	<input type="checkbox"/>
Blindness-both eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	Strabismus (Crossed eyes).....	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts.....	<input type="checkbox"/>	<input type="checkbox"/>	Tear film insufficiency (dry eyes).....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Other		
History of refractive surgery.....	<input type="checkbox"/>	<input type="checkbox"/>			

MEDICAL INFORMATION *(Continued)*

Allergies: Are you allergic or have you had a reaction to:

	Yes	No		Yes	No
Local anesthetics.....	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber).....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal.....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills.....	<input type="checkbox"/>	<input type="checkbox"/>	Animals.....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	Food/Other.....	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please specify		
Metals.....	<input type="checkbox"/>	<input type="checkbox"/>			

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

	Yes	No		Yes	No		Yes	No			
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes type I or type II..	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date			Eating disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please specify		
Artificial heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>				Malnutrition.....	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease...	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections.....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	GE Reflux/persistent heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type of infection		
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats.....	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease....	<input type="checkbox"/>	<input type="checkbox"/>	Systematic lupus erythematosus.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck.....	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice, or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Severe headache/migraines..	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Severe/rapid weight loss...	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells/seizures....	<input type="checkbox"/>	<input type="checkbox"/>	STDs/STIs.....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defects...	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please specify			ADD.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/Radiation treatment.....	<input type="checkbox"/>	<input type="checkbox"/>				ADHD.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease...	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion..	<input type="checkbox"/>	<input type="checkbox"/>	Gag Reflex Sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Processing Disorder.	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	Oral Sensory Sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>									

Has a physician recommended that you take antibiotics prior to your treatment?..... 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

