Social History

This information is kept strictly confidential. Please check the box if you would prefer to discuss this portion directly with the doctor.
☐ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes

If yes, please describe____

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long ____

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long ____

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long ____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ Covid 19

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

	No	Yes	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY			
Skin	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy/Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain/Soreness	☐	☐	☐
Chronic Infection of Eye Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐

	No	Yes	?
EARS/NOSE/MOUTH/THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above, or have a condition not listed, please explain_______________________________________

____

____

Contact Lens History

Have you ever worn contact lenses? ☐ Yes ☐ No What type of lens? ☐ Rigid ☐ Soft ☐ Toric ☐ Bifocal ☐ Other
Are you interested in getting a prescription for contact lenses today? ☐ Yes ☐ No - **Contact lens fitting is not covered by insurance, charge is $80.00**
Average contact lens wearing time _____________ Brand and age of current lenses______________
Do you sleep in your contact lenses? ☐ Yes ☐ No If so, how often? ______________________

Rate the following:		
	Overall lens comfort	☐ Excellent ☐ Fair ☐ Poor
	Distance Vision	☐ Excellent ☐ Fair ☐ Poor
	Near Vision	☐ Excellent ☐ Fair ☐ Poor

Please provide any additional information you would like to add:____

The information provided is true and complete to the best of my knowledge
Patient Signature (or Guardian if patient is a minor)____Date_______________
Name of Person Completing Form (if not patient) ____Relationship to Patient____________________

Review Date_________ ☐ Changes ☐ No Changes Provider signature______________
Review Date_________ ☐ Changes ☐ No Changes Provider signature______________

Patient Health History

Important Note**:** **DO NOT** send this information via email. Save this form to your computer, print it, and bring it to your exam. *Due to provisions of the Health Care Act of 2010 and other regulations, we are required to collect certain personal, race/ethnic, and language health related information. All personal information is confidential and protected. Please provide all. Information*

Patient Name____Date______________________________

General History

What is the primary reason for your visit today?____

If you are a new patient, what is the date of your last exam?____

Have you ever worn glasses? ☐ Yes ☐ No If yes, how old is your current pair of lenses________________________

Average time per day spent on computer____

Any history of ocular injuries or trauma____

Have you had eye surgery or laser treatment to your eyes? (*Please list*)____

____

What is your height?____ What is your Weight?_______________________________

Allergies and Medications

Last medical exam____

Please list any allergies: Medication____

Seasonal____

List any medications you take (*including oral contraceptives, aspirin, over the counter medications and home remedies*__________

____

List all major injuries, surgeries and/or hospitalizations you have had: ____

____

Are you pregnant and/or nursing? ☐ Yes ☐ No

Are you considering refractive surgery/LASIK at some time in the future? ☐ Yes ☐ No

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following condition:

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness	☐	☐	________________________
Cataract	☐	☐	________________________
Crossed Eyes	☐	☐	________________________
Glaucoma	☐	☐	________________________
Macular Degeneration	☐	☐	________________________
Retinal Detachment/Disease	☐	☐	________________________
Arthritis	☐	☐	________________________
Cancer	☐	☐	________________________
Diabetes	☐	☐	________________________
Heart Disease	☐	☐	________________________
High Blood Pressure	☐	☐	________________________
Kidney Disease	☐	☐	________________________
Lupus	☐	☐	________________________

Hobbies/Recreation/Sports *Please mark those that apply to you*: ☐ Crafts ☐ Hunting ☐ Skiing ☐ Music ☐ Painting ☐ Golf ☐ Boating/Fishing ☐ Gardening ☐ Photography ☐ Card playing ☐ Racquet/handball ☐ Flying ☐ Swim/scuba ☐ Other_____