# Patient History

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

**Patient's Name** ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. **Patient ID:**

Last Name | Middle | First Name | Suffix | Preferred | DOB (mm/dd/yy) | SSN

**Patient's Address** | **Address Line 2** | Primary Phone ☐ Home ☐ Mobile | Day/Work Phone

City | State | Zip | Country | Emergency Contact | Emergency Phone

Email | Person responsible for this A/C

Height ft in cm/m ☐ ft in ☐ cm ☐ m

Weight ☐ lbs ☐ kg

**Authorized to discuss health info** Name

Relationship to patient

**Sex** ☐ Male ☐ Female **Patient Status** ☐ Single ☐ Married ☐ Other **Student** ☐ Full Time ☐ Part Time **Employed** ☐

**Sexual Orientation**
- ☐ Straight/Heterosexual
- ☐ Gay/Lesbian/Homosex
- ☐ Bisexual
- ☐ Other
- ☐ Unknown
- ☐ Declined to Specify

**Gender Identity**
- ☐ Identifies as Male
- ☐ Identifies as Female
- ☐ Transgender Male ( Female to Male )
- ☐ Transgender Female ( Male to Female )
- ☐ Neither/Genderqueer
- ☐ Additional/Other Gender
- ☐ Declined to Specify

**Race & Ethnicity**
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African America
- ☐ Declined To Specify
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Not Hispanic or Latino

**Preferred language**
- ☐ English
- ☐ Spanish/Castilian
- ☐ Chinese
- ☐ Japanese
- ☐ Vietnamese
- ☐ Korean
- ☐ German
- ☐ French
- ☐ Declined To Specify
- ☐ Other

**Primary Insurance**

Insured's Name (First Name, Middle Initial, Last Name)

Insured's Address | Address Line 2

City | State | Zip | Country

Insured's ID No | Group No | Insured's DOB | Sex ☐ M ☐ F

Pt Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

**Secondary Insurance**

Insured's Name (First Name, Middle Initial, Last Name)

Insured's Address | Address Line 2

City | State | Zip | Zip

Insured's ID No | Group No | Insured's DOB | Sex ☐ M ☐ F

Pt Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

**How did you initially find our office? (Specify one)**

**Please Read:**

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____

# Patient History and Information

**Referring Physician**

☐ M.D. ☐ P.A. ☐ N.P. ☐ R.N. ☐ O.D. ☐ Is Primary Care Physician

| First Name | Middle | Last Name | Suffix | Clinic Name |
|---|---|---|---|---|
| | | | | |

| Clinic Address | City | State | Zip | Phone |
|---|---|---|---|---|
| | | | | |

**Health History**

Reason for today's exam

When was your last exam? When was your last health exam?

Past illnesses or injuries

Past surgeries

Current eye drops

Current medications

Reactions/sensitivities medicines

Specific allergies

**Current Eye Symptoms**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Glare Sensitivity | ☐ Yes ☐ No | Foreign Body Sensation | ☐ Yes ☐ No | Distorted Vision (Halos) | ☐ Yes ☐ No |
| Headaches | ☐ Yes ☐ No | Infection of Eye or Lid | ☐ Yes ☐ No | Double Vision | ☐ Yes ☐ No |
| Light Sensitivity | ☐ Yes ☐ No | Itching | ☐ Yes ☐ No | Flashes | ☐ Yes ☐ No |
| Tired Eyes | ☐ Yes ☐ No | Mucous Discharge | ☐ Yes ☐ No | Floaters or Spots | ☐ Yes ☐ No |
| Burning | ☐ Yes ☐ No | Drooping Eyelid | ☐ Yes ☐ No | Fluctuating Vision | ☐ Yes ☐ No |
| Dryness | ☐ Yes ☐ No | Redness | ☐ Yes ☐ No | Loss of Central Vision | ☐ Yes ☐ No |
| Excess Tearing/Watering | ☐ Yes ☐ No | Sandy or Gritty Feeling | ☐ Yes ☐ No | Loss of Side Vision | ☐ Yes ☐ No |
| Eyelid Swelling | ☐ Yes ☐ No | Blurred Vision Distance | ☐ Yes ☐ No | Loss Of Vision | ☐ Yes ☐ No |
| Eye Pain or Soreness | ☐ Yes ☐ No | Blurred Vision Near | ☐ Yes ☐ No | Other | ☐ Yes ☐ No |

**Eye History**

| | | | | | |
|---|---|---|---|---|---|
| Amblyopia (Lazy Eye) | ☐ Yes ☐ No | Dry Eye Syndrome | ☐ Yes ☐ No | PVD (Vitreous Detachment) | ☐ Yes ☐ No |
| Infection of Eye or Lid | ☐ Yes ☐ No | Eye Injuries | ☐ Yes ☐ No | Retinal Detachment | ☐ Yes ☐ No |
| Blindness | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Crossed Eyes | ☐ Yes ☐ No |
| Cataract | ☐ Yes ☐ No | Glaucoma Suspect | ☐ Yes ☐ No | Keratoconus | ☐ Yes ☐ No |
| Color Blindness | ☐ Yes ☐ No | High Risk Medication | ☐ Yes ☐ No | Corneal Disease | ☐ Yes ☐ No |
| Diabetic Retinopathy | ☐ Yes ☐ No | Macular Degeneration | ☐ Yes ☐ No | Other | ☐ Yes ☐ No |

**General Health Condition**

| | | | | | |
|---|---|---|---|---|---|
| Fever, Weight Loss, Fatigue, etc | ☐ Yes ☐ No | Kidney, Bladder issues | ☐ Yes ☐ No | Thyroid, Diabetes | ☐ Yes ☐ No |
| Ears, Nose, Throat issues | ☐ Yes ☐ No | Muscles, Bones, Joints issues | ☐ Yes ☐ No | Blood (Cholesterol, Anemia, etc) | ☐ Yes ☐ No |
| Cardiovascular (High BP etc.) | ☐ Yes ☐ No | Skin (Rash, Itching, etc) | ☐ Yes ☐ No | Allergic, Immuno | ☐ Yes ☐ No |
| Respiratory (Asthma) | ☐ Yes ☐ No | Neurological (Multiple Sclerosis) | ☐ Yes ☐ No | Pregnant | ☐ Yes ☐ No |
| Gastrointestinal | ☐ Yes ☐ No | Anxiety or Depression | ☐ Yes ☐ No | Nursing | ☐ Yes ☐ No |

# Medical History Questionnaire

## Family History

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Amblyopia (Lazy Eye) | ☐ Yes ☐ No | Macular Degeneration | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No |
| Blindness | ☐ Yes ☐ No | Retinal Detachment | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No |
| Cataract(s) | ☐ Yes ☐ No | Strabismus (Eye Turn) | ☐ Yes ☐ No | Lupus | ☐ Yes ☐ No |
| Color Blindness | ☐ Yes ☐ No | Arthritis | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| Eye Tumors | ☐ Yes ☐ No | Cancer | ☐ Yes ☐ No | Thyroid Disease | ☐ Yes ☐ No |
| Glaucoma | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Others | ☐ Yes ☐ No |
| Glaucoma Suspect | ☐ Yes ☐ No | Heart Disease | ☐ Yes ☐ No | | |

## Social History

Do you drink alcohol? ☐ No ☐ Occasional ☐ 1 Per Day ☐ 2-3 Per Day ☐ 4+ Per Day

Smoking status

Tobacco use cessation intervention, counselling? ☐ Yes ☐ No

Tobacco use cessation pharmacologic therapy? ☐ Yes ☐ No

Do you use illegal drugs ☐ Yes ☐ No

Do you engage in regular exercise? ☐ Yes ☐ No

Use nutritional supplements (vitamins etc.)? ☐ Yes ☐ No

Current occupation Years

Employer

Hobbies/Interests

## Spectacle Lens History

Do you use a computer? ☐ Yes ☐ No How many hours/day? Distance from Computer?

Do you drive? ☐ Yes ☐ No Mileage to work each way?

Do you have glare problems? ☐ Yes ☐ No

Visual difficulty when driving? ☐ Yes ☐ No

Problems with night vision? ☐ Yes ☐ No

Do you currently wear glasses? ☐ Yes ☐ No Since

Type of glasses ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Glasses owned ☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Trouble in the past with glasses? ☐ Yes ☐ No

Do you wear sunglasses? ☐ Yes ☐ No Are your sun glasses your current prescription? ☐ Yes ☐ No

## Special Eyewear Needs

☐ Computer (special prescriptions, special anti-glare tints or coatings)

☐ Occupational (mechanics, plumbers, pilots)

☐ Safety glasses (gardening, woodworking, welding)

☐ Sports/Hobbies (racquet sports, motorcycle)

## Contact Lens History

If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐ Yes ☐ No

Have you ever tried to wear contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

Type and brand of contact lenses

How many hours/day?

Reason for stopping?

Since

How many days/week?

Today's Wearing Time

**Please rate the following on a scale of 1-10, with 1 being POOR to 10 being Excellence**

| | Left | Right | What Solutions do you use? | |
|---|---|---|---|---|
| Lens comfort | | | Cleaner | |
| Distance vision | | | Disinfectant | |
| Near vision | | | Enzyme | |