PATIENT'S PERSONAL HISTORY - PLEASE COMPLETE ALL INFORMATION

Please Print

(THANK YOU!)

Last Name | First Name | Middle Initial | Title | Date

What are your visual problems & symptoms? _____ **How long?** _____

Please answer the following questions about your medical status and history.

1. Do you have any drug or food allergies? What are you allergic to? _____

   ❑ Yes ❑ No If yes, list symptoms: _____

2. Are you allergic to latex? ❑ Yes ❑ No If yes, list symptoms: _____

   _____

3. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, heart disease, stroke, asthma, cholesterol, thyroid problems, cancer or been hospitalized?

   ❑ Yes ❑ No If yes, please explain: _____

   _____

4. Have you ever had asthma, emphysema, or been treated for any breathing difficulties? ❑ Yes ❑ No

5. Have you ever been treated for any eye disease or had any eye surgery or eye injury?

   ❑ Yes ❑ No If yes, please provide date and details: _____

   _____

6. Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cataract, glaucoma, macular degeneration)?

   ❑ Yes ❑ No If yes, please specify family members with these conditions: _____

   _____

Family and Social History

Do you:	**Yes**	**No**	**Do you:**	**Yes**	**No**
Wear glasses*			Use eye drops (prescription & over the counter?) List:		
Wear contacts* ❑ Soft ❑ Hard					
Do you smoke? If yes, how much? ____ (packs) How Long? ____ (years)					
Do you drink alcohol? If yes, how much? ____			Do you work? If yes, how many hours per week? What kind of work do you do? List:		
How much do you weigh?					
Do you have Difficulty:			**Do you have Difficulty:**		
Driving? ❑ With Glasses ❑ Without Glasses			Seeing at night?		
With headlights? ❑ With Glasses ❑ Without Glasses			In bright light?		
Seeing road signs? ❑ With Glasses ❑ Without Glasses			Crossing the street?		
Reading? ❑ With Glasses ❑ Without Glasses			Recognizing the faces of people across the street?		

* Who wrote your prescription for the glasses/contacts you are wearing? _____

* When was your last visit to the optometrist? _____

PLEASE TURN PAGE OVER TO CONTINUE ▶

Review of Systems

Do you currently have any of the following problems:	Yes	No	If Yes, please explain
Chronic fever, fatigue, unexpected weight gain/loss	❑	❑	_____
Ear/nose/throat problems (e.g. hearing loss, sinus infection, sore throat)	❑	❑	_____
Heart problems (e.g. chest pain, irregular heart beat, high blood pressure)	❑	❑	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing, asthma)	❑	❑	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	❑	❑	_____
Urinary problems (e.g. pain or discomfort, blood in urine), difficulty voiding	❑	❑	_____
Skin problems (e.g. rashes, excessive dryness)	❑	❑	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	❑	❑	_____
Neurological problems (e.g. numbness, weakness, headache)	❑	❑	_____
Psychiatric problems (e.g. depression, anxiety)	❑	❑	_____
Endocrine problems (e.g. diabetes, thyroid disease)	❑	❑	_____
Blood problems (e.g. anemia, bleeding tendency)	❑	❑	_____
Have you ever been exposed to Hepatitis B?	❑	❑	_____
Have you ever been exposed to Hepatitis C?	❑	❑	_____
Have you ever tested positive for the HIV Virus?	❑	❑	_____

Do you drive? ❑ Yes ❑ No

Please list your prescription and over-the-counter medication, including vitamins and daily aspirin _____

_____

_____

_____

_____

- THANK YOU -

Please use space below if needed for further explanations.

_____ _____