Visual Health/History Form

Name_____Date_____

Current Job or Year in School _____ Hobby _____

Main Reason for today's visit

_____

_____

_____

Please check all that apply: __Dry __Burning __Stinging __Red __Sandy/gritty__Itchy __Mucous ___Tearing

Do you work on a computer? Y/N How many hours/day? _____

Last Eye Exam was _____Eye Doctor's Name _____

Date of Last Physical _____ Primary Care Dr. _____ at _____

Medications:

_____

_____

Allergy to Medications: _____

Do you have hayfever/seasonal allergies/food allergies? _____

Do you wear glasses? Y/N Do you wear Contact Lenses? Y/N

Have you had: Injuries/hard blows to head or eyes? _____
Any sudden loss of vision?_____

Do you see Flashes of Light? Y/N or Floaters? Y/N Do you see Double? Y/N

Have you had eye surgery ever? Y/N Please List:_____

_____

Tobacco Use? Y/N Quit? Y Packs/Day _____ Alcohol Use? Y/N/Only Rarely How many drinks/day? _____ Recreational Drugs? Y/N/Rarely May we ask what kind?_____

List any physical diseases or conditions: FOR YOURSELF Y / N Y / N Y /N __ __ Blindness __ __ Diabetes __ __ Arthritis __ __ Cataracts __ __ High Blood Pressure __ __ Thyroid Disease __ __ Glaucoma __ __ Stroke __ __ Kidney Disease __ __ Macular Degeneration __ __ High Cholesterol __ __ Cancer/Tumors __ __ Headaches __ __ Asthma/Emphysema __ __ Psychiatric __ __ Hepatitis __ __ HIV/AIDS
Other_____

FAMILY MEMBERS (parents, siblings, aunts, uncles, grandparents) Y / N Y / N Y /N __ __ Blindness __ __ Diabetes __ __ Arthritis __ __ Cataracts __ __ High Blood Pressure __ __ Thyroid Disease __ __ Glaucoma __ __ Stroke __ __ Kidney Disease __ __ Macular Degeneration __ __ High Cholesterol __ __ Cancer/Tumors __ __ Headaches __ __ Asthma/Emphysema __ __ Psychiatric __ __ Hepatitis __ __ HIV/AIDS
Other_____

How did you hear about us (Please Circle)?

Yelp Google Vision Insurance Website Friend/Family Referred _____ Other:_____