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Patient History Form

Patient name: _____
First name Middle name Last name

Date of Birth: _____ / _____ / _____
Month Day Year

Lifestyle Information

Do you work on a Computer? ☐ Yes / No ☐ How many hours per day? _____

Are you active in sports? _____ Hobbies? _____

_____ _____
Please list the sports above. Please list the hobbies above.

Do you use any of the following? ☐ Tobacco / ☐ Alcohol / ☐ Other substances: _____
Please check all that apply.

Patient Eye Information

How long since your last eye exam? _____ Do you wear glasses? ☐ Yes / No ☐

Do you wear contacts? ☐ Yes / No ☐ Type: _____ Interested in Contacts? ☐ Yes / No ☐

Have you been told you have:
Macular Degeneration? ☐ Yes / No ☐
Cataracts? ☐ Yes / No ☐
Glaucoma? ☐ Yes / No ☐

Are you bothered by: ☐ Sunlight / ☐ Night Glare / ☐ Dry Eyes / ☐ Double Vision / ☐ Distance Vision
☐ Near Vision / ☐ Floaters / ☐ Redness / ☐ Excessive Tearing / ☐ Itching
Please check all that apply.

Have you had any eye surgeries? ☐ Yes / No ☐ Type: _____ When? _____

Have you had an eye injury? ☐ Yes / No ☐ Type: _____ When? _____

Other eye diseases or problems? Please describe: _____

Personal Medical Information

Do you have any problems with any of the following?

☐ Allergies or Medicine Allergies	☐ Digestive System	☐ Respiratory System	☐ Arthritis
☐ High Blood Pressure / Heart Disease	☐ Sinus	☐ Blood Disorder	☐ Skin
☐ Nervous System	☐ Diabetes	☐ Psychological	☐ Thyroid

Please check all that apply.

Current Medication(s): _____
_____

Family History

Does your family have a history of any of the following?

☐ Glaucoma	Relation _____	☐ Retinal Detachment	Relation _____
☐ Cataracts	Relation _____	☐ Diabetes	Relation _____
☐ Macular Degeneration	Relation _____	☐ High Blood Pressure	Relation _____

Please check all that apply.

Other eye condition(s) _____ Relation _____
_____ _____

All information above is accurate to the best of my knowledge.

Signature: _____ **Date:** _____
Patient or authorized person's signature