Patient Health History Form

OPTICAL Fashions
EYE CARE CLINIC

Name_____

Date of Birth_____ Exam Date_____

Main reason for your visit today: ◯ **Exam** ◯ **Medical Visit** ◯ **Contact Lens Visit** ◯ **Glasses Recheck**
I am interested in: ◯ **Glasses** ◯ **Contact Lenses** ◯ **Laser Surgery/LASIK** ◯ **Other**_____

How did you hear about our office?_____

Current email address_____
(Due to privacy laws (HIPAA) we are not able to communicate your protected health information through email, if you consent to your protected health information being transmitted to the email address listed above please sign here.

Signature_____ Date_____

Current occupation/Sports/Hobbies (We like to know how you use your eyes)

_____

Preferred Language: ◯ English ◯ Other_____ ◯ Decline

Race: ◯ White ◯ African American ◯ Asian ◯ American Indian or Alskan Native
◯ Native Hawiian or Pacific Islaner ◯ Other_____ ◯ Decline

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Decline

Do you smoke or use tabacco? ◯ YES ◯ NO ◯ Former - If YES, how much? ☐ Everyday ☐ Some Days ☐ Heavy ☐ Light

Are you pregnant? ◯ YES ◯ NO Current Weight _____ Current Height _____ ☐ Decline

FAMILY HISTORY

YES	NO	Unknown		Relationship to You (Circle)					
◯	◯	◯	**Cancer**	Father	Mother	Brother	Sister	Son	Daughter
◯	◯	◯	**Diabetes**	Father	Mother	Brother	Sister	Son	Daughter
◯	◯	◯	**High Blood Pressure**	Father	Mother	Brother	Sister	Son	Daughter
◯	◯	◯	**Thyroid Dysfunction**	Father	Mother	Brother	Sister	Son	Daughter
◯	◯	◯	**Cataracts**	Father	Mother	Brother	Sister	Son	Daughter
◯	◯	◯	**Macular Degeneration**	Father	Mother	Brother	Sister	Son	Daughter
◯	◯	◯	**Glaucoma**	Father	Mother	Brother	Sister	Son	Daughter

(Continued on the back side)

PATIENT EYE HISTORY

Do you currently have any of these issues? Or, have you had any of these issues in the past?

(Check all that apply)	Currently	In the Past
Allergy/Hay fever	☐	☐
Blurry Vision	☐	☐
Corneal Abrasion	☐	☐
Crossed Eye/Eye Turn	☐	☐
Double Vision	☐	☐
Dry Eye	☐	☐
Eye Fatigue/Tired Eyes	☐	☐
Eye Infections	☐	☐
Eye Injury/Trauma	☐	☐
Flashes of Light	☐	☐
Floaters/Spots	☐	☐
Foreign Body in Eye	☐	☐
Headaches (frequent)	☐	☐
Itchy/Burning Eyes	☐	☐
Pain/Irritation	☐	☐
Red Eye	☐	☐
Sensitivity to Light	☐	☐
Vision Loss	☐	☐
Watery Eyes	☐	☐
Other Eye Problems		

_____

_____

*** Do you take Plaquenil/Hydeoxychloroquine?

◯ YES ◯ NO (This can affect your vision)

Please list your current medications with dosages here:

(Please also list any eye drops that you may be using and/or if you have a list of medications, we would be happy to make a copy for you instead.)

☐ None

_____

_____

_____

_____

_____

Please list your specific drug allergies here:

☐ None

_____

_____

_____

Your overall health can also affect the health of your eyes. Please help us take care of your eyes by letting us know about your medical health.

General:

☐ Fatigue Syndrome ☐ Cancer

☐ Developmental Disability

Ear/Nose/Throat:

☐ Sinusitis ☐ Dry Mouth

☐ Hearing Loss

Neurology:

☐ Multiple Sclerosis ☐ Migraines

☐ Epilepsy ☐ Cerebral Palsy

Psychology:

☐ Attention Deficit Disorder ☐ Depression

☐ Bipolar Disorder ☐ Anxiety

Cardiovascular:

☐ **Heart Disease** ☐ **Stroke** ☐ Elevated Cholesterol

☐ **HYPERTENSION** (high blood pressure)

Respiratory:

☐ Asthma ☐ Sleep Apnea

☐ Emphysema ☐ COPD

Gastrointestinal:

☐ Ulcer/Acid Reflux ☐ Celiac Disease

☐ Crohn's Disease ☐ Colitis

Urinary:

☐ Kidney Disease ☐ Prostate Disease/Cancer

☐ STD (Herpes/Chlamydia)

Muscle/Skeletal:

☐ Muscular Dystrophy ☐ Ankylosing Spondylitis

☐ Osteoporosis ☐ Fibromyalgia

Skin:

☐ Rosacea ☐ Eczema

☐ Psoriasis ☐ Herpes Simplex/Zoster

Endocrinology:

☐ **Thyroid Dysfunction** ☐ Hormone Dysfunction

☐ **DIABETES MELLITUS type 1**

☐ **DIABETES MELLITUS type 2**

Hematology/Lymph:

☐ Anemia ☐ **Elevated Cholesterol**

Allergies/Immunology:

☐ Lupus ☐ Rheumatoid Arthritis

☐ Sjogren's Syndrome ☐ Environmental Allergies

☐ Drug Allergies/Food Allergies

☐ **None** ☐ **Other: (Please List)**

_____

_____