PATIENT HISTORY AND INFORMATION

DATE _____

Name _____ Date of Birth ____/____/____
LAST FIRST MI NICKNAME

Address _____ Sex □ Male □ Female Age _____
STREET NAME

_____ Social Security Number _____
CITY STATE ZIPCODE

Home Telephone _____ Work/Cell Telephone _____

Date of Last Eye Exam ____/____/____ Email _____

Occupation _____ Employer _____

Primary Care Physician _____ Phone Number _____

Medical Insurance Carrier _____ PPO / PIO / HMO / Other

Do you have kids? Y/N If so, how many and what are their names? _____

How did you hear about us? Live in neighborhood / VSP website / lgeyecare website / friend or co-worker _____

GLASSES HISTORY

Do you wear glasses? □ Yes □ No
a) For: □ Near □ Distance □ Both
b) □ Single Vision □ Bifocals
□ Progressive □ Trifocals
c) Any Problems? _____
d) Do you wear sunglasses? □ Yes □ No
e) Are your sunglasses prescription? □ Yes □ No

CONTACT LENS HISTORY

Do you wear contacts? □ Yes □ No
Reason for stopping _____
a) □ Full Time □ Part Time □ Rarely
b) Type of Contacts?
□ Daily Wear □ Extended Wear
□ Soft Toric □ Gas Permeable
c) What cleaning solution do you use? _____
d) If you do not wear contacts, are you interested in trying them?
□ Yes □ No

SOCIAL HISTORY

Do you engage in regular exercise? □ Yes □ No
Do you drink alcohol? □ Yes □ No
Do you smoke? □ Yes □ No

Which of the following do you do regularly?

□ Night Driving
□ Commute 20+ minutes by car
□ Work under fluorescent light
□ Work on a computer
□ Watch television 3+ hours per day
□ Work at a desk
□ Work Outdoors
□ Work with small objects
□ Read for long periods
□ Travel on airplanes
□ Frequently alternate between indoors and outdoors
□ Other _____
□ List any sports or hobbies you participate in _____

OCULAR SURFACE DISEASE HISTORY

Do your eyes ever feel or do you experience:	Never	Slight	Moderate	Severe
Gritty or sandy sensation?				
Pain or soreness?				
Fluctuating vision?				
Occasional tearing?				
Blurred vision while reading or computer use?				
Discomfort in windy conditions?				
Discomfort in Heating/Air Conditioned areas?				

FAMILY MEDICAL HISTORY

EYE DISEASES

	Yes	No	Who		Yes	No	Who

Amblyopia (Lazy Eye)				Color Blindness			
Eye Tumor				Glaucoma			
Blindness				Macular Degeneration			
Cataract(s)				Retinal Detachment			

SYSTEMIC DISEASES

	Yes	No	Who		Yes	No	Who
Arthritis				High Cholesterol			
Cancer				Stroke			
Diabetes				Kidney Disease			
Heart Disease				Lupus			
High Blood Pressure				Thyroid Disease			

PATIENT MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Allergies (seasonal)			Glaucoma			Sandy or Gritty Feeling		
Excessive Weight Changes			Cataract(s)			Strabismus (Crossed Eyes)		
Ear, Nose, Throat			Macular Degeneration			Blurred Vision at Distance		
High Blood Pressure			Retinal Detachment			Blurred Vision at Near		
Asthma/Breathing Problems			Color Blindness			Distorted Vision (halos)		
Stomach Problems			Glare/Light Sensitivity			Double Vision		
Arthritis/Osteoporosis			Tired Eyes			Floaters or Spots		
Skin Problems			Amblyopia			Fluctuating Vision		
MS/Seizures			Burning Eyes			Loss of Vision		
Anxiety/Depression			Dryness			Loss of Side Vision		

Kidney Problems			Excess Tearing/Watering		
Diabetes			Eye Pain/Soreness		
Thyroid Problems			Itching		
Anemia/Blood Disorders			Mucous Discharge		
HIV/Herpes/ Lime Disease			Ptosis (drooping eyelid)		
Cancer (What type?):			Redness		

Eye injuries, infections or surgeries (including LASIK) _____

Any other surgeries _____

Medications that cause reactions or sensitivities _____

Specific Allergies _____

Current Medications (including vitamins & herbal supplements) _____

_____

Thank you for taking the time to help our office personalize your eye care. Your answers will help guide our doctors and staff to your specific needs. We look forward to seeing you for your examination and please feel free to let us know if you have any other needs or concerns we have not addressed.

_____ _____

Doctor's Signature Date