Patient History Form

Patient Name: _____ **Date of last eye exam:** _____

What are your main reasons for having your eyes examined today?

☐ Routine Examination ☐ Want information about Lasik eye surgery
☐ Wish to purchase new eyeglasses or sunglasses ☐ Wish to purchase contact lenses
☐ Experiencing any of the following symptoms (circle any that apply):
Eyestrain | Headaches | Dry Eyes | Allergies | Itching | Tearing | Floaters
Flashes of Light | Double Vision | Blurry Near Vision | Blurry Far Vision
Blurry Computer Vision | Other: _____

Do you currently wear: ☐ Eyeglasses ☐ Contact Lenses

Please list any questions or concerns that you would like addressed today: _____

_____

Personal Medical History:

Name of Physician: _____

Have you ever had any of the following eye conditions (check all that apply):

☐ Cataract Surgery ☐ Lazy Eye / Crossed Eyes ☐ Retinal Detachment ☐Glaucoma
☐ Macular Degeneration ☐ Lasik / RK / PRK ☐ Iritis ☐ Eye Injury
☐ Other: _____

Check any general health problems that you have, past or present:

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Cancer ☐ Kidney
☐ Arthritis ☐ Neurologic ☐ Asthma ☐ Heart Disease ☐ Thyroid ☐ Lupus
☐ Psychiatric ☐ Fever ☐ Weight Loss / Gain ☐ Other: _____

Please list any medications (including dosages) that you are currently taking: _____

_____

Please list any medications you are allergic to: _____

Insurance companies and medicare require us to ask if you smoke or consume alcoholic beverages.

Check any that apply: ☐ Smoke (# of packs per day, avg:_____) ☐ Alcohol ☐ Other Substance Use

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Family Medical History

{please note which family member experienced the condition by using the following codes:
P=Parent(s), GP=Grandparent(s) O=Other Family Member(s)}

Eye Conditions: _____Cataract Surgery _____Lazy Eye / Crossed Eyes _____Retinal Detachment _____Glaucoma
_____Macular Degeneration _____Lasik / RK / PRK _____Iritis _____Eye Injury
Other: _____

Health Problems: _____Diabetes _____High Blood Pressure _____High Cholesterol _____Cancer _____Kidney
_____Arthritis _____Neurologic _____Asthma _____Heart Disease _____Thyroid _____Lupus
_____Psychiatric _____Other: _____

I understand that I must be satisfied with the purchase of my frame as there is no return policy due to dissatisfaction of my frame choice, color, or size. If I choose to replace my frame I understand that 1) return policies may depend upon my insurance company's policies, and, 2) I am responsible for the cost of new lenses and frame at a reduced cost.

Signed: _____ **Date:**_____

OFFICIAL USE ONLY (10.01.15)

Previous Glasses RX

Dr. Reviewed Form
☐ Scan