Social Security No. _____

PATIENT HISTORY

COMPLETE BOTH SIDES

PATIENT NAME:_____ **TODAY'S DATE:**_____
First *Middle* *Last*

DATE OF BIRTH: _____ **AGE:**_____ **SEX:**_____ **MARITAL STATUS:**_____

RACE: _____ **ETHNICITY:** _____ **PREFERRED LANGUAGE:** _____

LOCAL ADDRESS: _____
Street *City* *State* *Zip Code*

HOME PHONE: _____ **WORK PHONE:** _____ **CELL PHONE:** _____

EMAIL ADDRESS: _____

PREFERRED METHOD OF COMMUNICATION: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Postal

PERSON RESPONSIBLE FOR ACCOUNT (If Different): _____ **Relationship:**_____

PERMANENT ADDRESS (If Different): _____
Street *City* *State* *Zip Code*

IF STUDENT: Grade_____ **School**_____

Occupation_____ **Employer**_____ **Address** _____

Aproximate date of last exam: _____ **By:** _____ **City:** _____

Main purpose of visit today: _____

Do you feel your prescription needs changing at: DISTANCE: ☐ Yes ☐ No **NEAR:** ☐ Yes ☐ No

REFERRED BY: Another Patient (Name)_____ **Newspaper (Name)**_____

Phone Book_____ **Website**_____ **Other**_____

OCULAR HISTORY: Have you ever had any of the following? (Please check positive responses only):

☐ Conjunctivitis ☐ Cataracts ☐ Glaucoma ☐ Amplyopia (Lazy Eye) ☐ Macular Degeneration

☐ Ocular Injury ☐ Visual Loss ☐ Strabismus ☐ Stye ☐ Photophobia

***Describe**_____

GENERAL HEALTH: In your past, or present, have you had any of the following? (Please check positive responses only):

☐ Allergies ☐ Drug Sensitivities ☐ Eye Surgery ☐ Smoker

☐ Asthma ☐ High Blood Pressure ☐ Eye or Head Injuries ☐ Alcohol Use

☐ Diabetes ☐ Skin Conditions ☐ Headaches* ☐ Other Substance Use

☐ Fainting ☐ Surgical Operations *When do you get them? _____

☐ Hay Fever ☐ Eye Diseases *Where do they hurt? _____

☐ Epilepsy ☐ Nervous System Problems ☐ Respiratory System Problems

FAMILY HISTORY

To date, has anyone in your family had any of the following? (Please check positive responses only and indicate relationship)

☐ Diabetes	☐ Any Eye Disease	☐ Glaucoma
_____	_____	_____
☐ Heart Disease	☐ Tuberculosis	☐ High Blood Pressure
_____	_____	_____
☐ Blindness	☐ Any Vascular Disease	☐ Tumors
_____	_____	_____

Eye Color:
☐ Brown ☐ Blue ☐ Green ☐ Hazel

Hobbies:
_____
_____

Are you presently taking any medications including birth control pills? _____ **If so, please state which ones and for what purpose:**

_____

_____

Date of last general health exam: _____ **Physician:** _____ **Phone:** _____

Please state any findings from the exam including pregnancy: _____

_____

Do you experience any eye strain, CRT discomfort, i.e. pain of any sort, spots occasionally, twitching eyelids? _____

When? _____ **How often?** _____

Have you ever worn contact lenses? _____ **If yes, what type?** _____

Who prescribed them? _____ **What city?** _____

Do you wear contact lenses now? _____ **If not, why did you quit?** _____

_____

When did you stop wearing them? _____

What type of contact lenses are you interested in wearing? _____

Receipt of HIPAA Notice of Privacy Practices:

Print Name: _____

Signature: _____ **Date:** _____