OPTOMETRIC HEALTH HISTORY

Date: _____ Patient's Name _____

Address: _____ Birth Date: _____

Occupation: _____ Hrs/Week: _____ Age: _____ Sex: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Who or How did you hear about us: _____ SS#: _____

Ocular History

Do you currently wear ☐ Glasses ☐ Contact Lenses ☐ Neither ☐ Both (when) _____

Do you currently have visual difficulty ☐ Reading ☐ Driving ☐ Other _____

Are you taking now, or have you ever taken, any medication specifically for your eyes? ☐ Yes ☐ No

If yes, please list: _____

Have you ever had eye surgery? ☐ Yes ☐ No If yes, describe below:

Surgery Type	Date	Left Eye	Right Eye	Both
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

Do you have, or have you ever had, any of the following conditions?

	Yes	No	If yes, when		Yes	No	If yes, when
Blurred vision	☐	☐		Foreign body feeling	☐	☐	
Burning	☐	☐		Glaucoma	☐	☐	
Cataracts	☐	☐		Halos	☐	☐	
Crusting on eyelid	☐	☐		Itching	☐	☐	
Decreased vision	☐	☐		Lazy eye	☐	☐	
Discharge	☐	☐		Light sensitivity	☐	☐	
Double vision	☐	☐		Macular degeneration	☐	☐	
Drooping eyelid	☐	☐		Pain	☐	☐	
Dryness	☐	☐		Retinal tear/detachment	☐	☐	
Flashes of light	☐	☐		Redness	☐	☐	
Floating spots	☐	☐		Wandering eye	☐	☐	

Other (describe): _____

Medical History

Are you currently being treated for: ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke

Have you ever had any operations, hospitalizations, or accidents requiring hospitalization? ☐ Yes ☐ No

If yes, please list: _____

Please list medications that you are currently taking including prescription, over-the-counter and supplements:

_____

_____

Please list all foods and medications to which you are allergic, including latex sensitivity:

_____

_____

Please complete the reverse side also

Family History

Do any blood relatives have the following?

Problem	Relation	Problem	Relation	Problem	Relation
Migraine		Diabetes		Overweight	
Epilepsy		Cancer		Infectious Disease	
Stroke		High Blood Pressure		Allergies	
Glaucoma		Heart Disease		Anemia	
Hearing Loss		Nephritis		Gout	
Rheumatic Fever		Arthritis		Other	
Heart Murmur		Thyroid Disease			

Social History

Please answer the following occupational and lifestyle questions relating to your optical health:
Any exposure to toxic or dangerous materials?

	Yes	No	When	Name or Type	What Symptoms	Other People Affected?
Insulation	☐	☐				
Fumes	☐	☐				
Metals	☐	☐				
Chemicals	☐	☐				
Plastics	☐	☐				
Solvents	☐	☐				
Dyes	☐	☐				
Other	☐	☐				

Social Habits

	Yes	No	When Started	When Stopped	Amount
Smoke	☐	☐			Packs Per Day
Coffee	☐	☐			Cups Per Day
Alcohol	☐	☐			Liquor/day Beer/day Wine/day
Other Drugs	☐	☐			Comments

Review of Systems

Do you have, or have you ever had, any of the following health conditions?

Problem	Yes	No	Date Began	Problem	Yes	No	Date Began
Convulsions/Seizures	☐	☐		Chest Pain with Exercise	☐	☐	
Decreased Hearing	☐	☐		Chest Pain at Rest	☐	☐	
Difficulty Swallowing/Soreness	☐	☐		Heart Murmur	☐	☐	
Dizzy/Balance Problems	☐	☐		Heart "Races"	☐	☐	
Frequent Earaches	☐	☐		Heart "Skips Beats"	☐	☐	
Frequent Headaches	☐	☐		Short of Breath at Night	☐	☐	
Frequent Nausea	☐	☐		Short of Breath at Rest	☐	☐	
Fainting	☐	☐		Short of Breath Exercising	☐	☐	
Often Stuffy Nose/Sneezing	☐	☐		Swollen Feet/Ankles	☐	☐	
Sinus Pain	☐	☐		Other Problems			

Insurance Information

INSURANCE NAME ID# GROUP#

NAME OF MEMBER DATE OF BIRTH SS#

I give authorization to have an eye exam, release information to a referring physician if medically necessary and want to be reminded of my next appointment. I authorize my insurance benefits to be paid directly to the above physician. Realizing I am responsible to pay noncovered services. I hereby authorize the release of pertinent medical information to insurance carriers and contracted insurance billing companies.

SIGNATURE: DATE:

PRIVACY NOTICE: You are entitled to a copy of our privacy policy, which details the steps taken to protect your personal information.

Please circle one: * YES, I want a copy * No thank you SIGNATURE: DATE:

You cannot be compelled to sign if you prefer not to sign please check here: ( ) - I prefer not to sign

For office use: OLD RX OD OS

Exam Type **Glasses** **Office Visit**
Contact lenses **sph / toric / multifocal**