Optical History — Child or Adult

To meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical and vision history.

Name: (Last) _____________________ (First) ____________________ (Middle) ______________ Date of Birth: _____________ Age: ____

Do you have a Primary Medical Provider (Family Doctor): ___ YES ___ NO

Do you have a Dentist: ___ YES ___ NO

Do you have a Therapist/Counselor: ___ YES ___NO

Eye Exam History –

____ Patient denies any past eye exams

Last eye exam: ______________ Location: ___________________ Doctor/Provider: ______________________________

Do you wear contact lenses? ___ YES ___ NO If yes, ___ Soft contacts ___ Gas perm contacts Do you sleep in your contacts? ___ YES ___ NO

Past Medical History –

Last physical exam: ________________ Location: ___________________ Primary care physician: ________________________

Have you ever had the following:

____ Patient denies any past illness

	Allergies		Chronic Diarrhea		Eczema		Heart Stent(s)		Numbness		CURRENT Fever
	Anemia		Chronic Bronchitis		Epilepsy		High Blood Pressure		Pacemaker		CURRENT Earache
	Angina		Constipation		Excess Thirst		High Cholesterol		Psoriasis		CURRENT Sore Throat
	Arrhythmia		COPD		Fainting		Joint Pain		Sinus Congestion		CURRENT Vomiting
	Arthritis		Decreased Hearing		Fatigue		Kidney Problems		Seizures		Other:
	Asthma		Dementia		Frequent Urination		Lupus		Stomach Ulcers		
	Bladder Problems		Depression		GERD		Migraines		Thyroid Dysfunction		Other:
	Cancer		Diabetes		Hay Fever		MS		Vertigo		
	Chronic Cough		Dry Mouth		Heart Disease		Muscle Pain		Weight Change		Other:

Have you ever been exposed to the following: ___ Gonorrhea ___ Hepatitis ___ HIV ___ Syphilis

Past Surgical/Injury History –

____ Patient denies any past surgeries

Please list all serious illnesses, operations, and other hospitalizations you have experienced and the dates these occurred

Medications – Please list all medication you are currently taking

_____ Patient denies any medications

**Please list all supplements, vitamins, and over the counter medications.

Current Medications	Dosage (mg)	How often per day

Allergies – Please list all food, medication, and environmental allergies

_____ Patient denies any allergies

Family History – Has any blood relative had any of the following: (Leave blank if uncertain)

Condition	Relationship to you	Condition	Relationship to you	Condition	Relationship to you
Cancer Type:		Thyroid Disease		Glaucoma	
Diabetes Type:		Macular Degeneration		Cataracts	
Heart Disease		Retinal Detachment		Blindness	
High Blood Pressure		Arthritis		Lazy Eye	

Social History

Tobacco: ____ Never ____Minimal ____YES (_____ packs/day x _____ years) _____ QUIT _____ Years ago (_____ packs/day x _____ years)

Alcohol: ____ Never ____Minimal ____ Less than 10 a week, ____ More than 10 a week, _____ QUIT _____ Years ago

Illicit Drugs: ____ Never ____Minimal ____ YES _____ QUIT _____ Years ago

Marital Status : ____ Single ____ Married ____ Widowed ____ Divorced ____ Separated

Education Level: ____ High School ____College ____ Post Graduate ____ Other

Occupation: ________________________________ Military Service: ___ YES ___ NO

Do you drive? ___ YES ___ NO Do you have trouble with driving vision? ___ YES ___ NO Do you have trouble with night vision? ___ YES ___ NO

Do you have difficulty with light sensitivity or glare? ___ YES ___ NO Do you work on a computer? ___ YES ___ NO

Do you wear protective eyewear for work? ___ YES ___ NO Do you require protective eyewear for sports? ___ YES ___ NO

Are you currently pregnant or breast feeding? ___ YES ___NO

Signature: ____ Date: __________________________