Visions Optique AND EYECARE

Patient Health History Information

Patient Information:

Patient's Name _____ Birthdate _____

Parent / Guardian name (if Patient is a minor) _____

Mailing Address _____

_____

(City) (State) (Zip Code + 4)

Cell Phone # (_____)_____

E-mail address _____ Occupation _____

How did you hear about us? _____

Medical Insurance Co. _____ Vision Insurance Co. _____

Primary Insured Name _____ Primary Insured Birthdate _____

Eye History:

Date of last eye examination: _____

Do you currently wear glasses? Yes No

Do you currently wear contacts? Yes No

Do you work on a computer? Yes No If so, how many hours/day _____

Have you had any of the following?

Amblyopia (lazy eye)	Yes	No
Cataract	Yes	No
Diabetic Retinopathy	Yes	No
Dry Eye Syndrome	Yes	No
Eye Injury	Yes	No
Glaucoma	Yes	No
Strabismus (eye turn)	Yes	No
Macular Degeneration	Yes	No
Retinal Disease	Yes	No

Have you had eye surgery for any of the following?

Cataract	Yes	No
Eye Injury	Yes	No
Foreign Body Removal	Yes	No
Laser Vision Correction	Yes	No
Retinal Detachment	Yes	No

Other (please list)_____

Medical History:

Are you taking any medications? Yes No Are you pregnant/nursing? Yes No

Please list any medications you are taking along with the dosage amounts
(including eye drops & over-the counter)

_____

_____

_____

Are you allergic to any medications? Yes No **If so, please list**

_____

Family Medical & Eye History:

Has anyone in your family had any of the following?

Amblyopia (lazy eye)	Yes	No	Cancer	Yes	No
Blindness	Yes	No	Diabetes	Yes	No
Macular Degeneration	Yes	No	Stroke	Yes	No
Glaucoma	Yes	No	Cholesterol	Yes	No
Retinal Disorder	Yes	No	Heart Disease	Yes	No
Strabismus (eye turn)	Yes	No	High Blood Pressure	Yes	No

Social History:

Do you use tobacco products? Yes No

If yes, what type? _____ How much?_____

If no, have you ever used tobacco products in the past? Yes No

Review of Systems:

Do you currently, or have you ever had problems in the following areas?

Eyes (Ocular symptoms)	**YES**	**NO**
Eye pain or soreness	☐	☐
Foreign body sensation	☐	☐
Fatigue/tired eyes	☐	☐
Dry/gritty feeling	☐	☐
Redness	☐	☐
Burning	☐	☐
Itching	☐	☐
Excess watering	☐	☐
Mucous discharge	☐	☐
Chronic infections	☐	☐
Chronic Styes	☐	☐
Glare/light sensitivity	☐	☐
Halos around lights	☐	☐
Double vision	☐	☐
Loss of vision	☐	☐
Blurred vision	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Vascular/Cardiovascular		
Heart disease/problems	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Stroke	☐	☐
Ear, Nose, Throat, Mouth		
Sinus infections	☐	☐
Hearing Loss	☐	☐
Respiratory		
Asthma	☐	☐
COPD	☐	☐
Chronic bronchitis	☐	☐
Emphysema	☐	☐
Sleep Apnea	☐	☐
Gastrointestinal		
Acid reflux	☐	☐
Intestinal problems	☐	☐
Liver/spleen problems	☐	☐
Genitourinary		
Genitals/kidney/bladder	☐	☐
Bones/joints/muscles		
Rheumatoid arthritis	☐	☐
Joint pain	☐	☐
Skin		
Rosacea	☐	☐
Metal allergies	☐	☐
Neurological		
Headaches/Migraines	☐	☐
Seizures	☐	☐
Alzheimer's	☐	☐
Parkinson's	☐	☐
Multiple Sclerosis	☐	☐
Endocrine		
Thyroid/other glands	☐	☐
Diabetes	☐	☐
Lymphatic/hematologic		
Anemia	☐	☐
Psychiatric		
Depression	☐	☐
Anxiety	☐	☐
Immune system		
Lupus	☐	☐
Cancer	☐	☐
Type _____		