PATIENT NAME:_____ DOB:_____

Please take a moment to complete our two-page health history form. It is very important that you provide complete and accurate information.

## DIABETES QUESTIONS

Are you diabetic? ❒ yes ❒ no (if yes, please complete this section)
Which type of diabetes? ❒ type 1 (juvenile) ❒ type 2 (adult onset)
What year were you diagnosed? _____

## MEDICATIONS

Please list any medications you are currently taking and what you are taking them for. This includes prescription and over the counter.

_____
_____
_____

Please list any drug allergies you have.

_____
_____

## PATIENT HISTORY

Do you have any diseases, syndromes, or symptoms related to the following systems? Please explain any checked answers in the space provided below.

| | | | | |
|---|---|---|---|---|
| Eye/Vision | ❒ retinal disease | ❒ cataracts | ❒ glaucoma | ❒ other |
| Cardiovascular | ❒ high blood pressure | ❒ heart | ❒ chest pain | ❒ other |
| Endocrine | ❒ urinary problems | ❒ thyroid | ❒ diabetes | ❒ other |
| Respiratory | ❒ emphysema/COPD | ❒ asthma | ❒ wheezing | ❒ other |
| Gastrointestinal | ❒ Crohn's Disease | ❒ ulcer | ❒ heartburn | ❒ other |
| Neurological | ❒ Multiple Sclerosis | ❒ Parkinson's | ❒ dementia | ❒ other |
| Psychiatric | ❒ depression | ❒ anxiety | ❒ insomnia | ❒ other |
| Social | ❒ alcohol consumption | ❒ smoking | ❒ unexpected weight change | |
| Other | ❒ presently pregnant | ❒ headaches | ❒ arthritis | ❒ cancer |
| | ❒ past surgery | ❒ past hospitalization or major illness/injury | | |

_____
_____
_____

## FAMILY HISTORY

Do any medical or eye diseases run in your family? Please explain any checked answers in the space provided below.

| | | | | |
|---|---|---|---|---|
| ❒ lazy eye | ❒ blindness | ❒ cataracts | ❒ color blindness | ❒ macular degeneration |
| ❒ arthritis | ❒ cancer | ❒ glaucoma | ❒ Multiple Sclerosis | ❒ high blood pressure |
| ❒ lupus | ❒ stroke | ❒ diabetes | ❒ thyroid disease | ❒ retinal detachment |
| ❒ thyroid | ❒ migraines | ❒ heart | ❒ kidney disease | ❒ other |

_____
_____

PATIENT NAME:_____ DOB:_____

## CURRENT EYE SYMPTOMS

Are you currently having any problems with any of the following symptoms? Please explain any checked answers in the space provided below.

| | | | | | |
|---|---|---|---|---|---|
| ❒ discharge from eye | ❒ headaches | ❒ tired eyes | ❒ lazy eye | ❒ burning | ❒ glare |
| ❒ drooping eyelid | ❒ eye pain | ❒ foreign body | ❒ eye infection | ❒ itching | ❒ dryness |
| ❒ distorted vision | ❒ redness | ❒ floaters | ❒ spots | ❒ double vision | |
| ❒ blurred vision | ❒ fever | ❒ vision loss | ❒ halos | ❒ other | |

_____

_____

## SOCIAL HISTORY

Please list your current occupation and employer:_____

Please list any hobbies:_____

Do you use a computer:_____ How often:_____

Do you have problems with night driving or glare:_____

## CONTACT LENS HISTORY

Do you currently wear contacts:_____ What type/how often:_____

Have you tried contacts in the past:_____ Reason for stopping:_____

## GLASSES HISTORY

Do you currently wear glasses:_____ ❒ full time ❒ distance ❒ near

Have you had problems with prior glasses:_____

## PRIMARY CARE PROVIDER

(Family Doctor, Nurse Practitioner, or Physician's Assistant)

Please list your primary care provider's name: _____

Address and phone number: _____

_____