

Patient History Record

Date: _____ Whom may we thank for referring you to our office: _____

Patient Name: _____ Birthdate: _____

Occupation: _____ Personal Physician: _____

Optometrist: _____ Referring Physician: _____

What brings you in to see us today? _____

Please answer the following questions about **your** medical status and history:

Please circle any of the following that you are being treated for or have been treated for in the past:

Diabetes	Strabismus	Retinal disease
High blood pressure	Cataract	Macular degeneration
Tuberculosis	Cancer	Blindness
Lupus	Glaucoma	Heart disease
Amblyopia	Serious eye injury	
Other: _____	Other: _____	

Have you ever had any **eye surgery** or **other surgery**?

No ____ If YES, Please explain: _____

Do you take any **medications**?

No ____ If Yes, Please list: _____

Do you take any **eye drops** or **medications for your eyes**?

No ____ If YES, Please list: _____

Do you have any drug or food allergies?

No ____ If YES, Please Explain: _____

Please circle any of the following problems that you are currently experiencing, or have experienced in the past:

Chronic fever	Vomiting	Irregular Heartbeat
Joint Pain	Abdominal	Urinary pain or discomfort
Blood in urine	Skin rashes	Excessive dry skin
Diarrhea	Shortness of breath	Numbness
Fatigue	Wheezing	Weakness
Hearing loss	Coughing	Paralysis
Sinus problems	Muscle aches	Anxiety
Sore throat	Swollen joints	Heartburn
Chest pain	Unexpected weight loss/gain	Headaches

Has anyone in your family ever been diagnosed with any of the following? Please circle.

Diabetes
High blood pressure
Tuberculosis
Lupus
Amblyopia

Strabismus
Cataract
Cancer
Glaucoma
Serious eye injury

Retinal disease
Macular degeneration
Blindness
Heart disease

Other: _____

Other: _____

Do you smoke? If Yes, how much? _____

Drink alcohol? If Yes, how much? _____

Do you wear contact lenses? No: _____ Yes: _____

If Yes what type? _____ Soft lenses _____ Rigid gas permeable lenses _____ Hard lenses

What Brand? _____

How often do you throw them away? _____

How many years have you worn contact lenses? _____

Do you sleep in your contacts? _____ No _____ Yes: How often? _____

What supplies or solutions do you use to take care of your contact lenses? _____

Do you wish to be fit for contact lenses or renew your contact lens prescription?

_____ No _____ Yes

IMPORTANT: For a **Contact Lens Fitting** or **Contact Lens Prescription Renewal**, there will be a fitting charge in addition to the standard examination fee that may or may not be covered by your insurance plan. Patient is responsible for any of these charges not covered by your insurance. These fees will be due at the time of service. Please speak to your insurance provider regarding complete details on this.

Please be sure to bring your Medications (or list of medications), Glasses and/or Contact Lenses with you.

Signed: _____ Date: _____