

Visual Health/History Form

Name _____ Date _____

Current Job or Year in School _____ Hobby _____

Main Reason for today's visit

Please check all that apply: Dry Burning Stinging Red Sandy/gritty Itchy Mucous Tearing

Do you work on a computer? Y/N How many hours/day? _____

Last Eye Exam was _____ Eye Doctor's Name _____

Date of Last Physical _____ Primary Care Dr. _____ at _____

Medications:

Allergy to Medications: _____

Do you have hayfever/seasonal allergies/food allergies? _____

Do you wear glasses? Y/N Do you wear Contact Lenses? Y/N

Have you had: Injuries/hard blows to head or eyes? _____

Any sudden loss of vision? _____

Do you see Flashes of Light? Y/N or Floaters? Y/N Do you see Double? Y/N

Have you had eye surgery ever? Y/N Please List: _____

Tobacco Use? Y/N Quit? Y Packs/Day _____ Alcohol Use? Y/N/Only Rarely How many drinks/day?
_____ Recreational Drugs? Y/N/Rarely May we ask what kind? _____

List any physical diseases or conditions: FOR YOURSELF Y / N Y / N Y / N Blindness Diabetes
 Arthritis Cataracts High Blood Pressure Thyroid Disease Glaucoma Stroke
 Kidney Disease Macular Degeneration High Cholesterol Cancer/Tumors Headaches
 Asthma/Emphysema Psychiatric Hepatitis HIV/AIDS
Other _____

FAMILY MEMBERS (parents, siblings, aunts, uncles, grandparents) Y / N Y / N Y / N Blindness
 Diabetes Arthritis Cataracts High Blood Pressure Thyroid Disease Glaucoma
 Stroke Kidney Disease Macular Degeneration High Cholesterol Cancer/Tumors
 Headaches Asthma/Emphysema Psychiatric Hepatitis HIV/AIDS
Other _____

How did you hear about us (Please Circle)?

Yelp Google Vision Insurance Website Friend/Family Referred _____ Other: _____