Name

Eyetopia Optometry

PATIENT HISTORY AND INFORMATION

Primary Care Physician

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

Health history

What is the main reason for today's exam ? When was your last exam ?

When was your last health exam ?

Past Illnesses or Injuries:

Past Surgeries:

Current Medications:

Current Eye Drops:

Medicines that cause reactions or sensitivities:

Specific Allergies:

EYE HISTORY

Glaucoma	○ Yes ○ No	Dryness	○ Yes ○ No	Strabismus (Crossed Eyes)	○ Yes ○ No
Cataract	○ Yes ○ No	Excess Tearing/Watering	○ Yes ○ No	Blurred Vision Distance	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Eye Pain or Soreness	○ Yes ○ No	Blurred Vision Near	○ Yes ○ No
Retinal Detachment	○ Yes ○ No	Foreign Body Sensation	○ Yes ○ No	Distorted Vision (halos)	○ Yes ○ No
Color Blindness	○ Yes ○ No	Infection of Eye or Lid	○ Yes ○ No	Double Vision	○ Yes ○ No
Headaches	○ Yes ○ No	Itching	○ Yes ○ No	Floaters or Spots	○ Yes ○ No
Glare/Light Sensitivity	○ Yes ○ No	Mucous Discharge	○ Yes ○ No	Fluctuating Vision	○ Yes ○ No
Tired Eyes	○ Yes ○ No	Drooping Eyelid	○ Yes ○ No	Loss of Vision	○ Yes ○ No
Amblyopia (Lazy Eye)	○ Yes ○ No	Redness	○ Yes ○ No	Loss of Side Vision	○ Yes ○ No
Burning	○ Yes ○ No	Sandy or Gritty Feeling	○ Yes ○ No		

GENERAL HEALTH CONDITION

Fever	○ Yes ○ No	Respiratory (Asthma)	○ Yes ○ No	Anxiety or Depression	○ Yes ○ No
Weight Loss	○ Yes ○ No	Gastrointestinal	○ Yes ○ No	Endocrine (Thyroid, Diabetes)	○ Yes ○ No
Other Symptoms	○ Yes ○ No	Kidney	○ Yes ○ No	Blood/Lymph	○ Yes ○ No
Ears,Nose,Throat	○ Yes ○ No	Muscles,Bones,Joints	○ Yes ○ No	Allergic	○ Yes ○ No
Cardiovascular (high blood pressure etc.)	○ Yes ○ No	Skin	○ Yes ○ No	Pregnant	○ Yes ○ No
		Neurological (Multiple Sclerosis)	○ Yes ○ No	Nursing	○ Yes ○ No

FAMILY HISTORY

Amblyopia (Lazy Eye)	○ Yes ○ No	Retinal Detachment	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Blindness	○ Yes ○ No	Strabismus (Eye Turn)	○ Yes ○ No	Kidney Disease	○ Yes ○ No
Cataract(s)	○ Yes ○ No	Arthritis	○ Yes ○ No	Lupus	○ Yes ○ No
Color Blindness	○ Yes ○ No	Cancer	○ Yes ○ No	Stroke	○ Yes ○ No
Glaucoma	○ Yes ○ No	Diabetes	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Heart Disease	○ Yes ○ No	Others	○ Yes ○ No

Name

Eyetopia Optometry
MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ○ No How many hours/day? _____ Distance from Computer? _____

Do you drive? ○ Yes ○ No Mileage to work each way? _____ Do you have glare problems? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No Since _____

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned

☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No _____

Do you wear sunglasses? ○ Yes ○ No Are your sun glasses your current prescription ? ○ Yes ○ No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings) ☐ Safety Glasses (gardening, woodworking, welding)
☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? _____

Do you currently wear contact lenses? ○ Yes ○ No Since _____

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 per day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Smoking Status _____

Method of Tobacco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No

Hobbies/ Interests : _____

Last Health Exam _____