Patient History Form

- ***Welcome to our Office! Please take a moment to fill out this Patient History Form.***

Do you currently wear glasses? _____
**If you answered Yes, What do you use your glasses for? (Please Check One):
|__| DV (Driving/ Everyday use)
|__| NV (Only to magnify small print)
|__| Progressive/BF (For both driving and small print)

Do you currently wear Contact Lenses? _____
**If you answered Yes, what type of contact do you currently wear? _____

Patient Information:

Reason for today's visit _____
Have you ever had eye injury or surgery? _____
Have you ever had double vision, floaters or flashes? _____
Please describe any headaches you get on a regular basis _____

When was your last visit to the eye doctor? _____
Have you ever had a dilated eye exam? _____
Are you taking any current medications? _____

Medication allergies or sensitivities? _____
Environmental allergies or sensitivities (Hay fever, latex, etc.) _____

For yourself or any blood relative, is there a history of the following: (if selected please explain who, etc.)

|__| Glaucoma	
|__| Cataracts	
|__| Macular degeneration	
|__| Retinal disease or detachments	
|__| Crossed or lazy eye	
|__| Other eye diseases	
|__| Diabetes	
|__| Heart disease, hypertension	
|__| Multiple sclerosis	
|__| Arthritis	
|__| Crohn's disease	
|__| Asthma, respiratory disease	
|__| Systemic lupus	
|__| Other immune system conditions	
|__| Anxiety or other psychological conditions	
|__| Currently smoking?	
|__| Pregnant?	

Attestation: The information provided is true and complete to the best of my knowledge. If any of this information should change, I will notify my office promptly

Patient Signature: _____ (Please Provide your name if you assisted the patient in completing the form)	Date: