

# Vision Patient History Form

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Have you ever had any eye injury or surgery? \_\_\_\_\_ Please explain \_\_\_\_\_

Have you ever had floaters or flashes? \_\_\_\_\_ Please explain \_\_\_\_\_

Please describe any headaches you get on a regular basis: \_\_\_\_\_

Have you ever had a dilated eye exam? \_\_\_\_\_ Would you like more info about a dilated eye exam? \_\_\_\_\_

Current medications \_\_\_\_\_

Medication allergies or sensitivities \_\_\_\_\_

Environmental allergies or sensitivities (Hay fever, latex, etc) \_\_\_\_\_

For yourself or your blood relatives is there a history of the following:

Please circle Yes or No

Yourself

Family

If yes, please explain (who, etc.)

	Yes	No	Yes	No	
Glaucoma					
Cataracts					
Macular degeneration					
Retinal disease or detachments					
Crossed or lazy eye					
Other eye diseases					
Diabetes					
High blood pressure, Hypertension, Heart Disease					
Multiple Sclerosis					
Arthritis					
Crohn's Disease					
Asthma					
Systemic Lupus					
Other Immune System Conditions					
Any other health issues?					
Anxiety or other psychological conditions?					
Are you currently smoking?					
Are you 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 the office promptly.

Patient signature \_\_\_\_\_

If you assisted the patient in completing this form please provide your name: \_\_\_\_\_

For office use only:

Review Date \_\_\_\_\_ Provider Signature \_\_\_\_\_

Review Date \_\_\_\_\_ Provider Signature \_\_\_\_\_

Review Date \_\_\_\_\_ Provider Signature \_\_\_\_\_