NEW PATIENT HEALTH HISTORY AND ACKNOWLEDGEMENT

Last Name:_____ First Name:_____ Date:_____
Address: _____
Communication Preference(s): Phone / Cell / Email / Text
Email:_____Phone(s)_____
DOB: ____/____/____ Age:_____ Gender: M F
Last Eye Exam:_____ Where:_____ Vision Ins_____
Medical Dr: _____ Health Ins:_____

Do you have any specific concerns about vision or eye care? _____
How did you find our office? _____

Past History:

Have you ever been diagnosed with eye problems: (*please circle*)
Cataract Glaucoma Macular Degeneration Other: _____
Have you ever had any eye surgeries: Y/ N If yes, what kind:_____
Please list medications if any: _____

Family History:

Has anyone in your family ever been diagnosed with: (*please list who*)
Cataract: _____ Glaucoma: _____ Macular Degeneration: _____
Other: _____
Hypertension: _____ Diabetes: _____ Eye Problems: _____

Social History:

Occupation or School Grade: _____ Tobacco: Y/ N / Quit Type: Smoking/ Chewing

Review of Systems:

Please mark the significant health history below:

Constitutional: None_____
- ☐ Developmental Disability
- ☐ Weight Loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other/ Medications

Ear, Nose, Mouth,. Throat: None_____
- ☐ Upper Respiratory tract infections
- ☐ Other/ Medications

Cardiovascular: None_____
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Other/ Medications

Respiratory: None_____
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other/ Medications

Gastrointestinal: None_____
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive
- ☐ Other/ Medications

Genitourinary: None_____
- ☐ Urinary Tract Infections
- ☐ Kidney Ailments
- ☐ STD-Viral Herpetic, Chlamydia
- ☐ Other/ Medications

Musculoskeletal: None_____
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis
- ☐ Other/ Medications

Dermatologic: None_____
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other/ Medications

Neurological: None_____
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Other/ Medications

Psychiatric: None_____
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Other/ Medications

Endocrine: None_____
- ☐ Non-Insulin Dependent Diabetes
- ☐ Insulin Dependent Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other/ Medications

Hematological/ Lymphatic: None____
- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Leukemia
- ☐ Other/ Medications

Allergic/ Immunologic: None_____
- ☐ Drug Allergy
- ☐ Environmental Allergy
- ☐ Rheumatoid Arthritis
- ☐ Lupus

(***Please fill out back***)

VISION CARE LIFESTYLE Questionnaire:

Which of the following visual demands do you encounter on a regular basis? (Circle all that apply)

Artificial Lighting
Board Work
Close-Up Work
Computer Work (Desktop/ Laptop/ Tablet/ Smart Phone)
Natural Lighting
Paperwork / Reading
Potential Eye Hazzards
Other:_____

Which of the following hobbies or activities do you participate in? (Circle all that apply)

Auto Repair
Biking
Boating/ Water Sports
Bookkeeping
Bowling
Competitive/ Spectator Sports
Computer
Drawing/ Painting
Driving
Fishing
Golf
Home Repairs
Hunting/ Shooting
Jogging/ Running
Landscaping/ Gardening
Musical Instruments
Pilot
Racquetball
Reading
Sewing/ Arts/ Crafts
Snow Sports
Tennis
Watching TV
Welding
Woodwork
Working out/ Gym/ Exercise
Other:_____

Do your eyes seem bothered by glare from any of the following situations? (Circle all that apply)

Car Headlights
Computer Monitor
Fluorescent Lighting
Haze
Night Driving
Sunshine
Traffic Lights
Other:_____

If you wear contact lenses, do you have:

- Current pair of prescription Glasses or Sunglasses? Yes/ No
  If so, how old are they?_____

- What do you like best about your contacts?_____
- What do you like least about your contacts?_____

Acknowledgement of Financial Responsibility:
I/ We acknowledge that even though insurance may be submitted, I/we are financially responsible for services and materials provided.

Acknowledgement of Privacy Policy:
I understand and agree that I have been offered and shown a copy of the privacy policy for Associates in Family Eyecare.

_____ _____

Signature *Date*