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:_________________________
SSN:_______________________ (or a copy of your drivers license)

Do you have any specific concerns about vision or eye care? ____
How did you find our office? Internet / Insurance / Friends or Family
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*