

ESTABLISHED HEALTH HISTORY AND ACKNOWLEDGEMENT

Legal First and Last Name: _____ DOB: _____ Date: _____
Nickname: _____ SSN: _____
Address: _____ City: _____ State: _____ ZIP: _____
Phone: **Cell / Home** _____ Email: _____
Communication Preference: **Phone / Cell / Text / Email** _____
Medical Dr: _____ Vision Ins: _____ Health Ins: _____

Do you have any specific concerns or questions about your eyes or vision? Yes / No

Medication List: _____

Has there been any change in your general health within the last year (new diagnoses, etc.)?

Family History:

Who (if anyone) in your family ever been diagnosed with: (Ex.: *Cataract: Mother*)
Cataract: _____ Glaucoma: _____ Macular Degeneration: _____ Other: _____
Hypertension: _____ Diabetes: _____ Eye Problems: _____

Social History:

Occupation/Career: _____ OR Current School Grade: _____
Do you drink alcohol? Y / N / Sometimes / Social Tobacco Use: Yes / No/ Quit Type: Smoke / Chew

What do you encounter in a typical day? (*Circle all that apply*)

Artificial Lighting	Paperwork / Reading	Potential Eye Hazards	Natural Lighting
Digital Devices	White-/ Chalk-board	Close-Up Work	Other: _____

What do you encounter on a regular basis? (*Circle all that apply*)

Arts/ Crafts	Music	Reading	Welding
Desktop Computer	Outdoor Sports	Shooting/ Hunting	Other: _____
Digital Devices	Outdoor Activities	Water Sports	

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

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

Do you wear contact lenses? Yes / No / Interested

What do you like *best* about your contacts? _____

What do you like *least* about your contacts? _____

Do you have a current pair of prescription glasses/ sunglasses? (*Circle all that apply*)

Distance only glasses Readers (near only) Distance and near Computer/workspace Sunglasses

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