NEW PATIENT HEALTH HISTORY

Legal First and Last Name:_____ DOB: _____ Date: _____
Nickname: _____ SSN: _____ Gender: M / F
Address: _____City: _____ State: _____ ZIP: _____
Communication Preference(s): **Home Phone / Cell / Text / Email**
Phone: **Cell / Home** _____ Email:_____
Last Eye Exam Year:_____ Eye Dr.: _____ Where:_____
Medical Dr:_____ Vision Ins:_____ Health Ins:_____
How did you find our office? Online / Insurance / Referral ***Please list who referred you***:_____

Do you have any specific concerns about your vision or eye care? _____

Eye Health History:

Have you ever been diagnosed with eye problems: (*please circle*)
Cataract Glaucoma Macular Degeneration Other: _____
Have you ever had any eye surgeries: **Yes / No** Surgery: _____ Year: _____ Surgeon: _____

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? **Yes / No / Sometimes / Socially** Tobacco Use**: Yes / No / Quit** Type: **Smoke / Chew**

Review of Systems:

Medication List: _____
_____

Please mark the significant health history below:

Constitutional: None ☐
- ☐ Developmental Disability
- ☐ Weight Loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other _____

Ear, Nose, Mouth, Throat: None ☐
- ☐ Allergies
- ☐ Chronic Cough
- ☐ Hard of hearing
- ☐ Sinus problems
- ☐ Other _____

Cardiovascular: None ☐
- ☐ Heart Surgery
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Other _____

Respiratory: None ☐
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Other _____

(Please fill out back)

Genitourinary: None ☐
- ☐ Urinary Tract Infections
- ☐ Kidney Ailments
- ☐ STD- Viral Herpetic, Chlamydia
- ☐ Other _____

Musculoskeletal: None ☐
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis
- ☐ Other _____

Dermatologic: None ☐
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other _____

Neurological: None ☐
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Other _____

Psychiatric: None ☐
- ☐ Depression
- ☐ Anxiety

Pyschiatric, cont…
- ☐ Bipolar Disorder
- ☐ ADD/ ADHD
- ☐ Other _____

Endocrine: None ☐
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other _____

Hematological/ Lymphatic: None ☐
- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Leukemia
- ☐ Other _____

Gastrointestinal: None ☐
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive
- ☐ Other _____

Allergic/ Immunologic: None ☐
- ☐ AIDs
- ☐ Environmental Allergy
- ☐ Lupus
- ☐ Drug Allergy_____
- ☐ Other _____

VISION CARE LIFESTYLE Questionnaire:

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

Artificial Lighting
White-/ Chalk-board
Close-Up Work
Computer Work (Desktop/ Laptop/ Tablet/ Smart Phone)
Natural Lighting
Paperwork / Reading
Potential Eye Hazards
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:_____

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*