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The information in this confidential personal history form is critical to the evaluation of your vision.

PATIENT HISTORY

Name: _____ Date: ___/___/___
Address:_____ Zip: _____
Home Phone #: (____) _____ Cell Phone #: (___) _____
Email Address: _____
Date of Birth: ___/___/___ Age: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our office? _____
If not referred, how did you choose our office for your visual needs?
□ Yellow Pages □ Sign/Building □ Internet □ Other: _____
Employer: _____ Work Phone: (____) _____ Ext: _____
Person Responsible for Account: _____

Date of Last Eye Examination: ___/___/___ Have you ever had vision therapy? ☐ yes ☐ no
Have you ever worn glasses? □ yes □ no Do you currently wear glasses? □ yes □ no
If yes, do you wear them for: □ distance only □ near only □ full-time □ computer work □ sports
Have you ever worn contact lenses? □yes □no Do you currently wear contact lenses? □ yes □ no
If yes, what type? _____
Have you had problems wearing contact lenses? □ yes □ no
If yes, describe. _____
Have you been told that you cannot wear contact lenses? □ yes □ no
Are you interested in trying contact lenses? □ yes □ no

This is your opportunity to tell us about the areas in which your vision is not serving you well.

What is your main reason for coming here today? _____
_____

Are there times you feel your vision (or present lens) is not quite right? _____
_____

Are there any activities that you would enjoy doing, but must restrict because of your vision? _____
_____

Are you interested in vision improvement? ☐ yes ☐ no
If yes, what type? □ vision therapy □ laser correction □ non-surgical

HEALTH HISTORY **Please check the conditions that apply to you or that run in your family.**

Allergies	□ self □ family	Turned Eye	□ self □ family
Respiratory Disease	□ self □ family	Color-blind	□ self □ family
Cancer	□ self □ family	Light Sensitivity	□ self □ family
Diabetes	□ self □ family	Eye Strain	□ self □ family
Drug Sensitivity	□ self □ family	Dry Eyes	□ self □ family
Elevated Cholesterol	□ self □ family	Floaters/Spots	□ self □ family
Heart Problems	□ self □ family	Flashing Lights	□ self □ family
High Blood Pressure	□ self □ family	Retinal Detachment	□ self □ family
Thyroid Problems	□ self □ family	Blindness	□ self □ family
Migraines/Headaches	□ self □ family	Cataracts	□ self □ family
Head Trauma	□ self □ family	Glaucoma	□ self □ family
Lazy Eye	□ self □ family	Eye Surgery/Injury	□ self □ family

Are you currently under a physician's care? ☐ yes ☐ no
Doctor's Name: _____

Are you regularly taking medications? ☐ yes ☐ no
If yes, please list and for what conditions?

_____
_____

How is your general health? □ Excellent □ Good □ Fair □ Poor Date of last physical: ___/___/___

OCCUPATIONAL HISTORY

What kind of work do you do?_____

What kind of activities do you do at work? (*Circle all that apply)*
driving typing data entry computers programming inspecting accounting writing/editing
using spreadsheets loading deliveries sales monitor instruments Other: _____

Do you use a computer at your job? □ yes □ no If yes, # of hours daily: _____
Do you use a computer at home? □ yes □ no If yes, # of hours daily: _____
What type of lenses do you use when at the computer? □ none □glasses □bifocals □contacts
When using the computer, do your eyes get..... □ red □ dry □ sore □ achy
Do you feel pain or discomfort in your……. □ neck □ back □ shoulders
Do letters ever seem to "swim"? □ yes □ no Does office lighting bother you? □ yes □ no
Do reflections and glare bother you? □ yes □ no Is it hard to proofread and find errors? □ yes □ no
Do you experience any of the following discomforts at work or at home?
□ headaches □ occasionally seeing double
□ eye strain □ pulling sensation near the eyes
□ sleepiness □ avoiding certain tasks
□ letters blurring as you read □ lose your place often
□ eyes red or watery
Does it take more and more effort to see clearly as the day wears on? □ yes □ no
Do you avoid reading after work, but read on weekends? □ yes □ no
Do you "hunch" closer to your work as the day wears on? □ yes □ no
Do street signs ever seem blurred as your drive home from work? □ yes □ no
Is it ever difficult to bring print or objects to clear focus? □ yes □ no
If yes, when? _____

RECREATION AND LEISURE

In what recreational activities do you participate? *(Circle all that apply)*
Reading racquetball tennis golf baseball basketball swimming camping sewing flying
Playing cards video games musical instruments
Other: _____
Do you wear special protective eyewear for your sport? □ yes □ no
Does your vision, or do your lenses, interfere with any activity? □ yes □ no
What are you doing, if anything, to protect your eyes from ultraviolet exposure? _____
_____
Do you currently wear glasses that have an anti-reflective coating? □ yes □ no
Is television viewing ever uncomfortable? □ yes □ no
If yes, how so? _____
Do you recline while watching television? □ yes □ no
Do you play video games often? □ yes □ no If yes, # of hours daily: _____
Do your lenses work for television? □ yes □ no

I have read and agree to all the provisions of the office financial policy.

Signed: _____ Date: ___/___/___