Health History

Patient Name:	**Date of Birth:**

Main Reason For Visit:

Primary Care Physician:

Race (Please Select One): American Indian or Alaskan Native Asian Black or African American Hispanic Native Hawaiian or Pacific Islander White Other Decline

Ethnicity (Please Select One): Hispanic or Latino Not Hispanic or Latino Decline

Preferred Language (Please select one): English Indian (Including Hindi & Tamil) Sign Language Spanish Other

Are you interested in contact lenses? Yes No **Occupation:**

Are you having any of the following vision concerns?		**Are you having any of the following eye concerns?**	
Blurred vision with current prescription?	Yes No	Redness?	Yes No
Eyestrain?	Yes No	Burning?	Yes No
Eye Pain?	Yes No	Itching?	Yes No
Severe sensitivity to light and / or night glare?	Yes No	Tearing?	Yes No
Headache?	Yes No	Discharge?	Yes No
Poor night vision?	Yes No	Any additional concerns?	
Double vision?	Yes No		
Any additional concerns?			

Alcohol Use: Never Rarely Moderately Daily **Tobacco Use** Never Yes Previous

Past Ocular History (Self)	
Glaucoma Suspect	Yes No
Glaucoma	Yes No
Retinal Hole	Yes No
Retinal Detachment	Yes No
Keratoconus	Yes No
Injury	Yes No
Dry Eye	Yes No
Inflammatory Disorder	Yes No
Cataract	Yes No
Patching	Yes No
Amblyopia	Yes No
Eye Turn / Cross Eyes	Yes No
Age Related Macular Degeneration	Yes No
Other:	

Family Medical History			
Hypothyroidism	Yes No	Father Mother Brother Sister Son Daughter
Hyperthyroidism	Yes No	Father Mother Brother Sister Son Daughter
Cancer	Yes No	Father Mother Brother Sister Son Daughter
Diabetes	Yes No	Father Mother Brother Sister Son Daughter
Hypertension	Yes No	Father Mother Brother Sister Son Daughter
Other:		

Family Ocular History		
Dry Eye	Yes No	Father Mother Brother Sister Son Daughter
Macular Degeneration	Yes No	Father Mother Brother Sister Son Daughter
Strabismus	Yes No	Father Mother Brother Sister Son Daughter
Retinal Detachment	Yes No	Father Mother Brother Sister Son Daughter
Amblyopia	Yes No	Father Mother Brother Sister Son Daughter
Cataract	Yes No	Father Mother Brother Sister Son Daughter
Glaucoma Suspect	Yes No	Father Mother Brother Sister Son Daughter
Glaucoma	Yes No	Father Mother Brother Sister Son Daughter
Other:		

Drug and / or Enviromental Allergies?