NORTHSIDE VISION

MEDICAL HISTORY

Today's Date: _____

PATIENT GENERAL INFORMATION

Name: _____ Age: _____ Occupation: _____

Name of General Physician: _____ Date of Last Eye Exam: _____

My Vision Problems Are (*All that Apply*): ☐Far ☐Near ☐Reading ☐At Computer ☐Driving ☐Sports/Outdoors ☐None

I Wear: (*Check All that Apply*) ☐ Prescription Glasses: How Old?_____ ☐ Prescription Sunglasses: How Old?_____

☐ Store-Bought Readers ☐ Store-Bought Sunglasses ☐ Safety Glasses for Work ☐ Sports Eyewear

Do You Currently Wear Contacts? ☐No ☐Yes ☐Not currently but I would like to

If Yes, What Type? ☐Rigid ☐Soft ☐Bifocal ☐Monovision ☐Colored

If You Do Not Currently Wear Contacts, Have Your Worn Them in the Past? ☐No ☐Yes

HOW CAN WE HELP YOU?

Please indicate all eye or vision complaints you are experiencing or have noticed in the past year:

Loss of Vision (In Center? Off to Side?) ..... ☐No ☐Yes

Double Vision..... ☐No ☐Yes

Distorted Vision, Halos, or Floaters ..... ☐No ☐Yes

Dryness or a Sandy or Gritty Feeling ..... ☐No ☐Yes

Light Sensitivity or Glare ..... ☐No ☐Yes

Tired Eyes or Headaches ..... ☐No ☐Yes

Not Seeing Clearly With Glasses/Contacts.... ☐No ☐Yes

Eyeglasses or Contacts Were Lost/Broken ..... ☐No ☐Yes

Difficulty Reading, Seeing Up Close ..... ☐No ☐Yes

Mucous Discharge..... ☐No ☐Yes

Redness, Itching or Burning Sensation..... ☐No ☐Yes

Foreign Body Sensation..... ☐No ☐Yes

Excess Tearing, Watery Eyes..... ☐No ☐Yes

Eye Pain or Soreness ..... ☐No ☐Yes

Eye or Lid Infections or Sties or Chalazia ..... ☐No ☐Yes

Need Protective Eyewear ..... ☐No ☐Yes

Difficulty In School, Referred By School Nurse ... ☐No ☐Yes

Other: _____

LIFESTYLE & VISUAL PERFORMANCE

Do you often spend more than two hours per day looking at a computer, a tablet PC or smart phone? ..... ☐No ☐Yes

Do you regularly spend more than two hours a day outdoors? ..... ☐No ☐Yes

Do you ever feel your lifestyle or activities are inhibited by your eye health or vision? ..... ☐No ☐Yes

Do you have family members in need of eye care? ..... ☐No ☐Yes

Do you have a pair of sunglasses offering 100% UV protection? ..... ☐No ☐Yes

What hobbies, activities and sports do you enjoy regularly? (List) _____

PLEASE CONTINUE ON NEXT PAGE . . .

PATIENT EYE & HEALTH HISTORY

Glaucoma ..... ☐No ☐Yes Explain: _____

Cataracts ..... ☐No ☐Yes Explain: _____

Macular Degeneration ..... ☐No ☐Yes Explain: _____

Watery or Dry Eyes ..... ☐No ☐Yes Explain: _____

Eye operations? ..... ☐No ☐Yes Describe: _____

Eye injury or retinal detachment? ..... ☐No ☐Yes Describe: _____

Other (Please List): _____

Do you use alchohol? ☐ Never ☐ Socially ☐ Daily (1-2 Drinks) ☐ Daily (3 or more Drinks)

Do you use tobacco products? ☐ Never ☐ In past ☐ Currently: How much _____

Do you use other substances? ☐No ☐Yes Describe: _____

Please list any medications, vitamins, or eye drops you currently take or use (or attach sheet): _____

_____

Please list any allergies or sensitivities: _____

PLEASE INDICATE ANY PROBLEMS WITH THE FOLLOWING HEALTH SYSTEMS:

ALLERGIC
Drug Sensitivities ..... ☐No ☐Yes
Hay Fever/ Pollen ..... ☐No ☐Yes
Other Allergies ..... ☐No ☐Yes

CARDIOVASCULAR
High Blood Pressure ..... ☐No ☐Yes
Heart Disease ..... ☐No ☐Yes
Vascular Disease ..... ☐No ☐Yes
Stroke ..... ☐No ☐Yes

CONSTITUTIONAL
Fatigue ..... ☐No ☐Yes
Developmental Disability ... ☐No ☐Yes

ENDOCRINE (GLANDS)
Type I Diabetes ..... ☐No ☐Yes
Type II Diabetes ..... ☐No ☐Yes
Thyroid ..... ☐No ☐Yes

GASTROINTESTINAL
Acid Reflux/ Heartburn ..... ☐No ☐Yes
Ulcer ..... ☐No ☐Yes

G.U./ REPRODUCTIVE
Prostate ..... ☐No ☐Yes
STD ..... ☐No ☐Yes
Pregnant or Nursing ..... ☐No ☐Yes

EARS/ NOSE/ THROAT
Hearing Impaired ..... ☐No ☐Yes
Sinus Problems ..... ☐No ☐Yes

HEMOTOLOGIC/LYMPHATIC
Leukemia ..... ☐No ☐Yes
Breast Cancer ..... ☐No ☐Yes

IMMUNOLOGIC
HIV/AIDS ..... ☐No ☐Yes
Lupus/ Sjögren's ..... ☐No ☐Yes

INTEGUMENTARY (SKIN)
Eczema/ Dryness ..... ☐No ☐Yes
Skin Cancer ..... ☐No ☐Yes

OTHER (LIST):

MUSCULOSKELETAL
Osteoarthritis ..... ☐No ☐Yes
Rheumatoid Arthritis ..... ☐No ☐Yes

NEUROLOGICAL
Headaches ..... ☐No ☐Yes
Migraines ..... ☐No ☐Yes
Epilepsy/ Seizures ..... ☐No ☐Yes
M.S. ..... ☐No ☐Yes
Dementia/ Alzheimer's ..... ☐No ☐Yes

PSYCHIATRIC/ MENTAL
ADD ..... ☐No ☐Yes
ADHD ..... ☐No ☐Yes
Depression ..... ☐No ☐Yes
Anxiety ..... ☐No ☐Yes
Learning Disorder ..... ☐No ☐Yes

RESPIRATORY
Asthma ..... ☐No ☐Yes
COPD or Oxygen Use ..... ☐No ☐Yes
Tuberculosis (TB) ..... ☐No ☐Yes

PATIENT'S FAMILY HISTORY LIST ANY BLOOD RELATIONS WHO HAVE ANY OF THE FOLLOWING:

Diabetes ..... ☐No ☐Yes Who? _____

High Blood Pressure ... ☐No ☐Yes Who? _____

Cataracts ..... ☐No ☐Yes Who? _____

Macular Degeneration ..... ☐No ☐Yes Who? _____

Glaucoma ..... ☐No ☐Yes Who? _____

Other ..... ☐No ☐Yes Who? _____

Patient Signature: _____ **Date**: _____

RETURNING PATIENTS: I have reviewed this form and indicated any changes below. Please sign and date at each visit.

Date Reviewed	Patient Signature	Changes to History		Please List/Describe Changes:
_____	_____	☐ None	☐ Yes:	_____
_____	_____	☐ None	☐ Yes:	_____
_____	_____	☐ None	☐ Yes:	_____
_____	_____	☐ None	☐ Yes:	_____
_____	_____	☐ None	☐ Yes:	_____