FAMILY VISION DEVELOPMENT CENTER

Patient History Form

Name: (First)_____(MI)_____(Last)_____ Gender: M F

Address: _____ City:_____ State:_____ Zip:_____

Telephone: (H)_____ (Cell / Work)_____ DOB: ____/____/____ SSN: _____-____-_____

Occupation: _____ Employer:_____ Email:_____ Single ☐ Married ☐

Health Insurance Carrier:_____ Vision Insurance Carrier:_____

Have you ever been to this office before? Yes ☐ No ☐ When was your last eye exam? _____

Eye Health / History: (please check all that apply)

What problem(s) are you currently having?

☐ Blurred Vision	☐ Burning	☐ Discharge	☐ Pain/Soreness
☐ Halos/Glare	☐ Itching	☐ Headaches	☐ Contact Lens Issues
☐ Flashes/Floating Spots	☐ Dryness	☐ Watery Eyes	☐ Side Vision Loss
☐ Redness	☐ Double Vision	☐ Foreign Body Sensations	☐ Other_____

Have you ever been told you have any of the following or have a family history of these? (check all that apply)

☐ Cataracts	☐ Glaucoma	☐ Retinal Detachment(s)	☐ Melanoma of the eye
☐ Dry Eye	☐ Macular Degeneration	☐ Retinitis Pigmentosa	☐ Corneal Dystrophy
☐ Lazy Eye (Amblyopia)	☐ Crossed Eyes (Strabismus)	☐ Blindness	☐ Other_____

Do you now wear contact lenses? ☐ Yes ☐ No If no, have you worn them in the past? ☐ Yes ☐ No

Are you interested in contact lenses even for occasional use? ☐ Yes ☐ No

Have you ever had an eye injury, surgery or severe eye infection? ☐ Yes ☐ No Explain_____

Medical History: (please check all that apply to you; circle if only a family history)

Approximate Height_____	☐ Anxiety	☐ Ulcers	☐ Thyroid disease
Approximate Weight_____	☐ Bipolar Disorder	☐ Depression	☐ Rheumatoid arthritis
☐ Sinus Issues	☐ Heart disease	☐ Degenerative disk	☐ Lupus
☐ Hearing loss	☐ Arterial disease	☐ Muscular Dystrophy	☐ Sjogren's disease
☐ Multiple Sclerosis	☐ Hypertension	☐ Fibromyalgia	☐ HIV/AIDS
☐ Cerebral Palsy	☐ High Cholesterol	☐ Osteoporosis	☐ Smoker
☐ Parkinson's disease	☐ Asthma	☐ Rosacea	☐ Alcoholism
☐ Migraine headaches	☐ COPD	☐ Shingles	☐ ADD/ADHD
☐ Stroke	☐ Colitis	☐ Diabetes Type I	☐ Concussion
☐ Currently Pregnant	☐ Crohn's Disease	☐ Diabetes Type II	Other_____

Medications: (please list any current medications you take; if you do not know the name, then what you take it for)

1._____ 2._____ 3._____ 4._____

5._____ 6._____ 7._____ 8._____

Are you allergic to any medications? Yes ☐ No ☐ Please list_____

Are there any other conditions we should know about? Yes ☐ No ☐ Explain_____