

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

PLEASE PRINT

Prof/ Mr/ Mrs/ Ms/ Miss/ Dr. (Please circle one)

Name _____ Date _____ Date of Birth _____

Age _____ Address _____ City _____ ZIP _____

Phone number: Home (____) _____ Work (____) _____ Ext. _____ {e-mail address ?} _____

Employer _____ Driver's License # _____

Social Security # ____ / ____ / ____ Person Responsible for account _____

Name of insurance carrier or group with identification number: _____

Date of your last eye examination _____ Have you ever had vision therapy? Yes No

Have you ever worn glasses? Yes No Do you wear glasses now? Yes No

If yes: for distance only for near only wear them full time

Are you interested in knowing more about refractive surgery? Yes No

Are you interested in knowing more about Contact Lenses? Yes No

What is your main reason for coming here today?

Are there times when your vision (or present lens) isn't quite right? _____

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

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

- Allergies Self Family Lazy eye Self Family
Respiratory disease Self Family Turned eye Self Family
Diabetes Self Family Color "blind" Self Family
Drug sensitive Self Family Light sensitive Self Family
Elevated cholesterol Self Family Eyestrain Self Family
Heart problem Self Family Dry eyes Self Family
High blood pressure Self Family Floaters/spots Self Family
Thyroid Self Family Flashing lights Self Family
Migraine or headaches Self Family Retinal detachment Self Family
Head trauma Self Family Cataracts Self Family
Glaucoma Self Family
Macular degeneration Self Family
Eye surgery or injury _____

Are you currently under a physician's care? No Yes Why? _____

Are you regularly taking pills or medications? No Yes Please specify _____

Do you use cigarettes/tobacco? _____ Alcohol? _____

VERY IMPORTANT! NEW PATIENTS: Who may we thank for referring you to our office?

Name of friend or relative: _____

If not referred, how did you choose our office for your visual needs? Please circle the appropriate answer:

- Saw the office -- School screening -- Yellow Pages -- Insurance -- Health Fair -- Website

Other?: _____

To our ESTABLISHED PATIENTS: Did you come in today as a result of a recall notice? Yes? No?

Do you wear contact lenses at this time? Yes No What type lenses do you wear? _____
 Have you had problems wearing contacts? Yes No Describe _____
 Have you been told you cannot wear contacts? Yes No Are you interested in trying contacts now? Yes No

OCCUPATION: What kind of work do you do? _____

What activities do you do at work: *(Circle all that apply)* Typing, computers, inspecting, data entry, accounting, writing/editing, using spread-sheets, driving, loading, deliveries, sales, monitor instruments.

Other activities: _____

Do you use a computer on your job? Yes No # of hours daily _____
 What lenses do you wear? glasses bifocals contacts multifocals None
 When computing, do your eyes get red dry ache
 Do you feel pain or discomfort in your neck shoulder back
 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 proof-read, or find errors? Yes No
Do you use a computer at home? Yes No # of hours daily _____

Do you experience any of the following discomforts at work or at home?

- Headaches? Letters blur as you read? Occasionally see double?
- Eyestrain? Eyes red or watery? Pulling sensation near eyes?
- Get sleepy? Lose your place often? Do you avoid certain tasks?
- Does it take more and more effort to see clearly as the day wears on?
- Do you avoid reading after work, but read on weekends? How long can you read? _____
- Do you "hunch" closer to your work as the day wears on?
- Do street signs ever seem blurred as you drive home from work?
- Is it ever difficult to bring print or objects to clear focus? When _____

RECREATION AND LEISURE:

In what recreational activities do you participate? *(Circle all that apply)* Read, racquetball, tennis, golf, baseball, basketball, swim, camp, sew, play cards, flying, video games, musical instruments.

Other recreational activities _____

Do you wear any special or protective eyewear for your sport? Yes No

Does your vision, or do your lenses, interfere with any activity? Yes No

What are you doing to protect your eyes from ultraviolet exposure? _____

Do you currently wear glasses that have an antireflective coating? Yes No

Television: is viewing ever uncomfortable? Please describe your discomfort: _____

Do you recline while viewing? Yes No Do your lenses work for TV? Yes No

Do you often play video games? Yes No # of hours daily _____

Signature of responsible party _____

Insurance Disclaimer: I understand I am financially responsible, whether my insurance company pays or not, for all charges incurred by me. I further agree that in the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should such court action be required. I agree that a photocopy of this authorization shall be valid as the original.