Overlake EyeCare, PS

Patient History Form

PATIENT NAME:

1. Your reason for visiting our office today? (Check all that apply)

   Note: Many insurance co.'s DO NOT cover routine eye examinations, therefore check ALL symptoms that apply.

   [ ] General/Routine check up
   [ ] Broken/lost contact lenses
   [ ] Eyes itch/painful/uncomfortable
   [ ] Filmy vision
   [ ] Broken/lost glasses
   [ ] Eyes red/swollen/tired
   [ ] Flashes of light
   [ ] Desire contact lenses
   [ ] Eyes burn/dry/gritty
   [ ] Eye strain
   [ ] Floaters/spots in vision
   [ ] Blurred distance vision
   [ ] Eyes crossed/wander
   [ ] Double vision
   [ ] Light sensitivity
   [ ] Blurred near vision
   [ ] Eye discharge/mucus/water
   [ ] Headaches/migraines
   [ ] Night blindness
   [ ] Other, please explain ______________________

2. Date of last eye examination ______________ Age of present glasses ______________ Age of present contacts ______________
3. Have you worn contacts in the past? [ ] No [ ] Yes When? ______________. Type? [ ] Soft [ ] Gas Perm [ ] Hard
4. Do you work on a computer? [ ] No [ ] Yes Hours per day? ______________.
5. Do you have special visual needs? [ ] No [ ] Yes Please list type of special activity? ______________
6. Are you currently taking medication? [ ] No [ ] Yes Please list. ______________
7. Are you allergic to any medication? [ ] No [ ] Yes Please list. ______________
8. Have you had or are you being treated for any of the following conditions? (Check all that apply)

Condition	No	Yes	Details?
Environmental allergies.	[ ] No	[ ] Yes	Details? ______
Arthritis or musculoskeletal disease.	[ ] No	[ ] Yes	Details? ______
Blood or lymph disease.	[ ] No	[ ] Yes	Details? ______
Cancer.	[ ] No	[ ] Yes	Details? ______
Thyroid or endocrine disease.	[ ] No	[ ] Yes	Details? ______
Ear, nose, mouth or throat disease.	[ ] No	[ ] Yes	Details? ______
High blood pressure, heart or vascular disease.	[ ] No	[ ] Yes	Details? ______
Lung or respiratory disease.	[ ] No	[ ] Yes	Details? ______
Neurologic or psychiatric disease.	[ ] No	[ ] Yes	Details? ______
Recent weight loss or fever.	[ ] No	[ ] Yes	Details? ______
Rosacea or skin disease.	[ ] No	[ ] Yes	Details? ______
Stomach or gastrointestinal disease.	[ ] No	[ ] Yes	Details? ______
Urinary or kidney disease.	[ ] No	[ ] Yes	Details? ______
Tobacco use.	[ ] No	[ ] Yes	
Eye injury, surgery or laser treatment.	[ ] No	[ ] Yes	Details? ______

9. Do you or any of your blood relatives have any of the following conditions? (Check all that apply)

Condition	No	Self	Relative	Who?
Diabetes.	[ ] No	[ ] Self	[ ] Relative	Who? ______
Glaucoma.	[ ] No	[ ] Self	[ ] Relative	Who? ______
Cataracts.	[ ] No	[ ] Self	[ ] Relative	Who? ______
Macular degeneration.	[ ] No	[ ] Self	[ ] Relative	Who? ______

CHANGES

DATE	CHANGES TO HISTORY