PATIENT HEALTH HISTORY FORM (EMR use)

1. Glasses Currently owned: □ Distance □ Reading □ Bifocal □ Progressive □ Sunglasses □ Safety
2. Contacts currently worn: □ Soft Lenses □ Multifocal Lenses □ Toric Lenses □ RGP Lenses

   □ I do not currently wear contact lenses but would like to try.

(Fitting Fee will be applied for any evaluation for contact lens rx. Fees vary depending on contact lens type. Cost of contact lens material is always separate.)

3. **Please tell us what you are currently experiencing. Please check all appropriate boxes.**

□ Blurry Vision □ Headache around eyes □ Dryness

□ Foreign Body □ Watery Eyes □ Sandy/Gritty Feeling

□ Double Vision □ Mucous Discharge □ Floaters/Flashes of light

□ Distorted Vision □ Redness in/around eye □ Loss of Peripheral Vision

□ Fluctuating Vision □ Eye Pain/Soreness □ Diabetic Eye Exam □ Other:____________

4. **Please review your Current/History medical conditions. Check all appropriate boxes.**

□ Ear,Nose,Throat □ Cardiovascular □ Neurological □ Musculoskeletal

□ Gastrointestinal □ Integumentary(skin) □ Endocrine □ Allergic □ Psychiatric

□ Lung Disease □ Hypertension □ Arthritis □ Cancer □ Respiratory

Explain:____
____

4. **Patient Self History**: □ Glaucoma □ Cataract □ Macular Degeneration
   □ Injuries:____
   □ Surgery:____

5. **List of Current Medications (including any eye drops):**
   ____
   ____

Allergies to medications:____

6. **Hobbies/Sports:** □ Golf □ Tennis □ Computer □ Reading □ Jogging
   □ Swimming □ Soccer/baseball □ Bike Riding □ Sewing/Crafts □ Other____________

7. **Family History**: □ Hypertension □ Diabetes □ Arthritis □ Cancer □ Thyroid

   □ Other: ____

8. **Social History**: □ Cigarette Smoking Frequency__________ □ Alcohol – Frequency________

   Are you interested in Aesthetic care? Please circle all that apply.

   Anti-Aging Botox Filler Skin Care