SOUTHSIDE
EYECARE & OPTICAL

HEALTH HISTORY

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HEALTH HISTORY

Patient name: ______________________________

	Yourself		Blood Relative	
	YES	NO	YES	NO
AIDS/HIV				
Arthritis				
Autoimmune disease				
Bleeding				
Cancer				
Depression				
Diabetes				
Drug sensitivity				
Epilepsy				
Heart condition				
Hepatitis (specify type)				
High blood pressure				
Singles				
Sinus problems				
Skin condition				
Stroke				
Thyroid condition				
Glaucoma				
Macular degeneration				

Primary physician: ____________________________________

Are you pregnant? YES / NO
Do you smoke? YES / NO
Do you drink? YES / NO

The purpose of my visit today is:
A. Routine exam (incl. glasses/contacts)
B. Medical visit incl. eyes, pain, discharge, flashes, etc.
C. Other (list)

List any prior surgeries:

List medications, incl. eye drops:

List allergies (drugs or other):

EYE HEALTH

Please check all that apply

- Blurred near vision ☐
- Blurred distance vision ☐
- Problems with glasses ☐
- Problems with contacts ☐
- Crossed eyes ☐
- Discharge ☐
- Double vision ☐
- Dry eyes ☐
- Eye injury ☐
- Eye strain ☐
- Floaters or spots ☐
- Fluctuating vision ☐
- Foreign body ☐
- Itching / watering ☐
- Light sensitivity ☐
- Migraines / headaches ☐
- Poor night vision ☐
- Red eyes ☐
- See halos / flashes ☐
- Temporary vision loss ☐
- Twitching lid ☐

Date of last eye exam: __________________

When do you wear glasses? (indicate all that apply)

A. Never
B. Seldom
C. Always
D. While watching TV
E. While reading
F. While driving
G. Other (specify)

Do you wear contact lenses? YES / NO

Type of lens: __________ Hours per day: ________

List any problems you are experiencing with your contacts or glasses.

Do you have any other complaints?

To the fullest of my knowledge, I have accurately and truthfully completed my health and eye history.

______________________________ Patient's signature (or parent/legal guardian) __________ Date

______________________________ Physician's signature __________ Date