Name: _____ D.O.B: _____ Date: _____ PT # _____

HEALTH HISTORY: Please answer for **ALL CONDITIONS** as they apply to you **AND if there is family history**.

	Patient	Patient	Family		Patient	Patient	Family
ADD / ADHD	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Neurological Disorder	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Allergies	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Seizure Disorders	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Autism	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	STD (Sexually Transmit Disease)	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Cancer	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Thyroid	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Cerebral Palsy	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Blindness	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Developmental Delays	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Cataracts	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Diabetes – **Type 1**	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Color "blind"	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Diabetes – **Type 2**	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Dry Eyes	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Drug sensitive	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Eye Turn/Strabismus	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Dyslexia	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Eyestrain	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Elevated Cholesterol	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Flashing lights	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Gastrointestinal Disease	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Floaters/Spots	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Glandular Disorder	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Glaucoma	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Head trauma	❑ No-Pt	❑ Yes-Pt		Lazy eye /Ambylopia	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Headache/Migraine	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Light sensitive	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Heart problem	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Macular degeneration	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
High blood Pressure	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Retinal detachment	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Learning Disabilities	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Eye surgery or injury _____			
Muscular Disorder	❑ No-Pt	❑ Yes-Pt	❑ Yes-Family	Other _____			

PRIMARY OR FAMILY DOCTOR **Are you currently under a doctor's care?** ❑ **No** ❑ **Yes**

Dr's Name: _____ City: _____ Phone # _____

Date of your last physical _____ **Are you taking any medications regularly?** ❑ No ❑ Yes ➔List below & on back

Please list ALL MEDICATIONS (*INCLUDING OVER THE COUNTER MEDICATIONS*) & the reason you take them:

1 _____ for _____

2 _____ for _____

3 _____ for _____

(LIST ANY ADDITIONAL MEDICATIONS ON THE BACK) ❑ **YES,** ***MORE MEDICATIONS ARE ON THE BACK***

PAIN OR DISCOMFORT: **Do you experience ANY of the following?** (***CHECK ALL THAT APPLY***)

❑ Headaches ❑ Sensitivity to light ❑ Eyestrain ❑ Occasionally see double ❑ Any blind spots ❑ Blurred vision

❑ Eyes red or watery ❑ Eyes dry ❑ Pulling sensation near eyes Other: _____

❑ Any pain? **Where** _____ **When** _____

❑ **NONE OF THE ABOVE**

IS THERE ANYTHING ELSE YOU WISH TO TELL THE DOCTOR? ❑ No ❑ **YES** ➔ *please use the back of this form*

Signed ⊗ _____ Signature _____ Date ➔ _____

If not the patient, PRINT YOUR NAME: _____ Relationship to patient: _____

Modified 10/22/2011

THANK YOU VERY MUCH FOR YOUR TIME AND EFFORT IN FILLING OUT OUR FORMS.

Pt Name: _____ DOB: _____ Pt. # _____

Is there anything else you wish to tell the doctor?

_____

_____

_____

_____

_____

List **additional medications** here (*including over the counter medications*) and why you take them

Medication		Reason
_____	for	_____
_____	for	_____
_____	for	_____
_____	for	_____
_____	for	_____