Weaver Eye Care Associates Patient History Form

Name: _____ Nickname: _____
Last First Middle Initial

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/_____ Marital Status: □ Single □ Married □ Divorced □ Other

Sex: □ Male □ Female Employment: □ Employed □ Student □ Retired □ Other

Social Security #: ____-___-_____ Home Phone: (___) ____-_____ Cell Phone: (___) ____-_____

Work Phone: (___) ____-_____ Email: _____

Family Doctor's Name, Practice Name, Phone #: _____
_____

Emergency Contact Name: _____ Contact Number: (___) ____-_____

How did you hear about our office: □ Newspaper Ad □ Billboard □ Mailing □ Signage □ Facebook
□ Website □ Google/Internet Search □ Friend/Family, name_____

Employer/School Name: _____ Occupation/Grade: _____

Medical Health Insurance (Primary): _____

Medical Health Insurance (Secondary): _____

Vision Insurance Plan: _____

Current Medications (please list names and dosage):_____
_____

Are you having any problems with your eyes today: _____

PAST, FAMILY & SOCIAL HISTORY

Do **YOU** have a history of: □ Glaucoma □ Cataracts □ Macular Degeneration □ Eye Surgery □ Lazy Eye/Strabismus □ High Blood Pressure □ Diabetes □ Other _____

Does **ANYONE** in your family have a history of (please write relationship): □ Glaucoma _____
□ Cataracts _____ □ Macular Degeneration _____ □ Eye Surgery _____
□ Lazy Eye/Strabismus _____ □ High Blood Pressure _____ □ Diabetes_____

□ Y □ N Do you drive?
□ Y □ N Do you use alcohol or tobacco? If so, how often and what type? _____

Your estimated: Height _____ Weight _____ Any Allergies: _____

REVIEW OF SYMPTOMS
Do you currently have:
□ Y □ N Rheumatoid arthritis, lupus, sarcoidosis, HIV/AIDS, or any inflammatory conditions? _____
_____
□ Y □ N Any glaucoma, cataracts, macular degeneration, eye surgery, eye inflammation, blurred vision, double vision or any eye condition? _____

□ Y □ N Fibromyalgia, muscular dystrophy, osteoarthritis, ankylosing spondylitis or any musculoskeletal conditions? _____

□ Y □ N Heart disease, hypertension, stroke, vascular disease, high cholesterol, or any heart conditions? _____
□ Y □ N Crohn's disease, colitis, ulcers, or any digestive conditions? _____

□ Y □ N Multiple sclerosis, epilepsy, Alzheimer's, Parkinson's, TIA/stroke, headaches/migraines, or any neurological conditions? _____

□ Y □ N Weight loss, fever, fatigue, trauma or any developmental disability?_____

□ Y □ N Chlamydia, STD, genital herpes, or any genitourinary conditions? _____

□ Y □ N Depression, panic disorder, anxiety, schizophrenia, disorientation, memory loss, confusion, dementia, mood swings, nervousness or any psychiatric conditions? _____

□ Y □ N Upper respiratory tract infection, ear ache, runny/stuffy nose, sore throat, ringing of the ears/tinnitus, decreased hearing or any other ear, nose, mouth or throat condition? _____

□ Y □ N Anemia, bleeding problems, bruising, leukemia or any blood condition? _____

□ Y □ N Asthma, bronchitis, emphysema, smoking, COPD, lung cancer, pneumonia, tuberculosis or any respiratory conditions?_____

□ Y □ N Type 1 Diabetes, Type 2 Diabetes, thyroid dysfunction, hormonal dysfunction or any endocrine conditions? _____

□ Y □ N Eczema, rosacea, psoriasis, dermatitis, rashes, or any skin conditions? _____

□ Y □ N Any Metallic devices / pieces in your body? _____

LIFESTYLE QUESTIONS

□ Y □ N Are you interested in purchasing eyeglasses and/or contact lenses today?

□ Y □ N Do you wear eyeglasses? □ Distance □ Reading □ Bifocals □ Trifocals □ Progressives □ Full-time wear □ Part-time wear

□ Y □ N Do you wear contact lenses? □ Hard lenses □ Soft lenses □ Daily disposable □ Two-week □ Monthly □ Overnight wear □ Every day □ Socially Brand name: _____

□ Y □ N Do you have difficulty driving at night/in the rain, or sensitivity to sunlight/bright lights?

□ Y □ N Do you spend a lot of time outdoors or driving during the day?

□ Y □ N Do your eyes ever feel dry, itchy, gritty or irritated?

Do you participate in any sports?
□ Boating □ Racquetball □ Skiing/Snowboarding
□ Tennis □ Golf □ Basketball □ Fishing □ Baseball / Softball
□ Running □ Soccer □ Football □ Hunting □ Other_____

How many hours do you use a computer at work and at home each day? _____

Do you experience any of the following symptoms while using a computer? If so, please indicate:
□ Headaches □ Burning eyes □ Blurred vision □ Dry eyes
□ Eyes feel tired □ Double vision □ Head, shoulder or neck pain
□ Words running together

What fine detail near vision activities do you enjoy or perform often?
□ Carpentry □ Cooking □ Gardening □ Card playing/Bingo □ Piano/organ/music
□ Painting □ Reading □ Needle point/Knitting/Crocheting □ Cell phone use
□ Puzzles/Crossword □ Hand-held video games □ Other _____

□ Y □ N Are you interested in having LASIK surgery or would like more information about the procedure?

□ Y □ N Are you interested in contact lenses that allow you to read without glasses?

□ Y □ N Are you interested in changing your eye color with contact lenses?

Patient's Signature: _____ **Date:** _____

Thank you very much for completing this history form. The doctor and Weaver Eye Care Associates staff will review your entries. They will ask you further questions as necessary, so that we may customize an eye examination just for you!