

IRONTON VISION CENTER

HEALTH HISTORY FORM

Mr. _____ Date _____
 Mrs. _____
 Ms. _____

Patient's Statement of Ocular Problems and Reason For Visit

Chief Problem: _____

Are you interested in contact lenses? _____ Clear or color? _____

Other Problems: _____

Family Physician: _____ Other Physicians _____

Are you allergic to any medications: Yes No If yes, what are they? _____

Do you have any other allergies that you know of? Explain: _____

Have you had or do you have any of the following medical problems? **PLEASE INDICATE YES OR NO. IF YES, EXPLAIN.**

	YES	NO	
Skin/Breast (rashes, lumps, eczema, psoriasis, acne)	[]	[]	_____
Head/Neck (injury, surgery, pain, headache, bumps)	[]	[]	_____
Ears (hearing, ache, discharge)	[]	[]	_____
Nose, sinuses (frequent colds, allergies, drip)	[]	[]	_____
Mouth, throat (teeth, gums, soreness, swallowing)	[]	[]	_____
Lungs (asthma, emphysema, cough, wheezing)	[]	[]	_____
Heart (attack, rhythm, failure, pain, racing)	[]	[]	_____
Vascular (high blood pressure, clots, aneurysm)	[]	[]	_____
Stomach (ulcer, colitis, heartburn, constipation)	[]	[]	_____
Genitourinary (kidney failure, stones, pain, blood)	[]	[]	_____
Liver (hepatitis, gall bladder, jaundice)	[]	[]	_____
Musculoskeletal (arthritis, fractures, pain, weak)	[]	[]	_____
Neurologic (stroke, parkinson's, dizziness, numbness tremor, shakes, seizures, fainting)	[]	[]	_____
Endocrine (diabetes, thyroid)	[]	[]	_____
Lymphatics (swelling, lymph nodes, neck glands)	[]	[]	_____
Blood (bruising, low blood count, anemia, leukemia)	[]	[]	_____
Psychiatric (depression, nervousness, tension)	[]	[]	_____
Infectious Disease (TB, AIDS, vaccine reactions)	[]	[]	_____

OCULAR HISTORY:

When & where was your last eye examination: _____ findings (if not here) _____

Have you ever had an eye disease (glaucoma, cataracts, retinal detachment, macular degeneration, crossed eyes, lazy eye, etc.) _____

Do you currently use any eye drops or medication or vitamins for your eyes? What? _____

FAMILY HISTORY: Does anyone in your family have any of the following diseases? (Blood relative)

Disease:	YES	NO	Family members with problem other than husband/wife
Glaucoma	[]	[]	_____
Cataract	[]	[]	_____
Retinal detachment	[]	[]	_____
Crossed Eyes / Lazy Eye	[]	[]	_____
Blindness	[]	[]	_____
Cancer	[]	[]	_____
Diabetes	[]	[]	_____
High blood pressure, heart disease	[]	[]	_____
Kidney disease	[]	[]	_____
Tuberculosis	[]	[]	_____
Stroke	[]	[]	_____
Macular degeneration	[]	[]	_____
Other	[]	[]	_____

Social History:

What is your current Occupation: _____ What were your past occupations? _____

Please check the appropriate answer:

In your current living situation do you live alone live with a family member or friend?

Do you live in your own home, trailer, or apartment extended care facility other? _____

Is your mobility impaired? NO YES. If YES are you able to walk need a walker or cane.

Can you go up and down stairs? _____

Do you work longer than an hour on a computer at work or home? YES NO. If YES explain _____

What activities do you enjoy? sports music crafts sewing computer cards/games TV driving
 reading.

Do you participate in any sports? tennis football racketball 4-wheels motorcycle soccer baseball
 other _____

Do you currently smoke? NO YES If YES, how long and how many packs a day? _____

If you don't currently smoke but you did once, how long ago and for how long and why did you quit? _____

Do you currently drink more than three alcoholic drinks a day? YES NO

Are you on a special diet or taking Vitamins? YES NO If YES, explain _____

Have you had any problems with weight loss, fever or fatigue, unexplained pain? YES NO

Are you having any of the following eye problems:

Disturbance of vision?

- Blurred vision near / distant
- Halos around lights
- Floaters / specks
- Light flashes / lightning
- Blind spots / loss of sight
- Must sit close to TV
- Distortion of vision / waves
- Double vision
- Reading problems
- Difficulty with road signs
- Problems reading medicine labels
- Rubs eyes a lot

Pain/Discomfort?

- Foreign body sensation
- Deep pain or ache
- Tenderness / lid pain
- Burning / itching am / pm
- Sensitivity to light
- Nausea / dizziness
- Sharp stabbing pain
- Can't open eyes
- Blinks eye a lot

Abnormal secretions?

- Excessive tearing or watering
- Crusting or sticking together lids
- Flakes / crust in lashes
- Dry / Gritty collecting in corners
- Heavy mucus / mattering
- Blood coming from eyes

List All Current Medications:

List Hospitalizations / Surgeries / Illness

Subsequent reviews of history dated above:

Complete review: _____ init. _____

Complete review: _____ init. _____

Complete review: _____ init. _____

Complete review: _____ init. _____

Complete review: _____ init. _____

Complete review: _____ init. _____

Complete review: _____ init. _____

Complete review: _____ init. _____

Changes Noted: _____