Natural Eyes of Weston Confidential Health History

Name _____ Date: _____

Please check all that apply

Today's Visit: ❑ Eye Exam ❑ Contact Lenses ❑ Eye Infection or Injury
❑ Eyeglasses ❑ Glaucoma ❑ Cataract ❑ LASIK ❑ Other_____

Personal Eye Information

Do you have any eye conditions or problems? _____

Computer use per day: ❑ Occasional ❑ A few hours ❑ Many hours

Do you have any of the following?

❑ Wear Eyeglasses ❑ Eye Medications ❑Sensitivity to Light ❑ Eye Allergy
❑ Wear Contact lenses ❑ Eyes Itch/Burn ❑Flashes Floaters/Spots ❑ Water/Dryness
❑ Eye Surgery or Injury ❑ Cataract Surgery _____

Medical History

Are you allergic to any medications? ❑ No ❑ Yes _____

Do you currently, or have you ever had any problems in the following areas? ❑ No
❑ Allergic/Immunologic ❑ Blood/Lymph ❑ Bones/Joints ❑ Cardiovascular ❑Endocrine/Thyroid
❑Ears/Nose/Throat ❑Fever (today) ❑ Gastrointestinal ❑ Respiratory ❑ Urinary/Kidney
❑ Mental/Depression ❑ Headaches/Neurological ❑ Skin conditions
❑ Pregnant/Nursing ❑ Diabetes _____A1C_____

Are you taking any medications? ❑ No
❑ Medications including non-prescription _____
Medical Doctor_____ Last Physical _____

Family History

Do any eye conditions occur in your family? ❑ No ❑ Yes _____
❑ Glaucoma ❑Blindness ❑ Retinal Detachment
❑ Cataracts ❑ Macular Degeneration ❑ Other _____
Do any Medical conditions occur in your family? ❑ No ❑ Yes _____
❑ Diabetes ❑ Hypertension ❑ Other _____

Social History *Some insurance companies require that we ask these questions. This information is kept strictly confidential, however you may discuss this portion directly with the doctor if you prefer.*

❑ I would prefer to discuss my social history directly with the doctor (check box)

Do you drive? ❑ Automobile ❑Boat ❑ Motorcycle ❑ Other _____
Do you require any specific visual needs? ❑ No ❑ Yes _____
❑ Piano/Music ❑ Occupational/Safety ❑ Other_____
Do you use: ❑ Tobacco products ❑ Alcohol ❑ Marijuana ❑ Other drugs
Have you been exposed to: ❑STD ❑Hepatitis ❑Herpes ❑HIV