Patient Health History

Community Eye Care of Indiana

Name:_____ DOB:_____ Acct#:_____

Are you experiencing any of the following symptoms today or recently?:

Blurred/ Decreased Vision	Headache/Migraines	Dry/Watery/Gritty Eyes
Flashes and/or Floaters	Light Sensitivity	Eye Pain/Irritation
Trouble Driving At Night	Glare/Halos Around Lights	Matting/Crusting Eyelids

Past/ Current Ocular History:

Retinal Detachment	LASIK/PRK/RK	Laser Treatment	Cataract Surgery
Macular Degeneration	Glaucoma	Low Vision/Blindness	Trauma/Injury to Eye

Do you currently wear prescription glasses? **Y N**
Over the counter readers? **Y N**
Do you currently wear contact lenses? **Y N**
Are you interested in wearing contact lenses? **Y N**

Please circle any of the following conditions and/or symptoms that apply to you today:

Cardiovascular	High Cholesterol High Blood Pressure Heart Disease Irregular Heart Beat Atrial Fibrillation Congestive Heart Failure
Constitutional	Fever Weight Loss Weight Gain Fatigue Loss of Appetite Chills Night Sweats
Endocrine	Diabetes: Year Diagnosed:_____ Date of Last A1c:_____ Last A1c:_____ Last Blood Sugar:_____ Thyroid Disorder Excessive Thirst Excessive Urination Heat/Cold Intolerance Hair Loss
Gastrointestinal	Reflux Crohn's Ulcerative Colitis Irritable Bowel Syndrome Hepatitis ____ Nausea Vomiting Diarrhea Gastric Bypass Blood in Stool
Genitourinary	Prostate Problems Kidney Disease Pain/Burning with Urination Genital Sores/Ulcers
Hematologic/ Oncology	Cancer _____ Leukemia Easy Bruising Prolonged Bleeding HIV/AIDS
Ear/Nose/Throat	Seasonal Allergies Sinusitis Hearing Loss Dry Mouth Ear Ache Pain with Chewing
Skin	Rash Skin Sores Itching Loss of Hair Rosacea Eczema
Musculoskeletal	Arthritis Gout Lupus Joint Pain Muscle Aches Swollen Joints Uses Wheelchair/Walker
Neurologic	Multiple Sclerosis Alzheimer's Parkinson's Seizures Stroke Poor Balance Migraine/Headache Dizziness Numbness/Tingling Tremor Weakness Paralysis

Respiratory	Sleep Apnea COPD Bronchitis Asthma Wheezing Cough Oxygen Use Shortness of Breath

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Name:_____ **DOB:**_____ **Acct#:**_____

Surgery History (Including Heart, Gastrointestinal, Back/Neck):

_____

Allergies to Medications:_____

Latex:_____Food:_____

Medications (Including Eye Drops, Vitamins/Supplements, and Over The Counter Medications)

_____

_____

_____

Family History (Please Circle All That Apply):

Macular Degeneration	Mother	Father	Grandmother	Grandfather	Sister	Brother
Glaucoma	Mother	Father	Grandmother	Grandfather	Sister	Brother
Blindness	Mother	Father	Grandmother	Grandfather	Sister	Brother
Heart Disease	Mother	Father	Grandmother	Grandfather	Sister	Brother
High Blood Pressure	Mother	Father	Grandmother	Grandfather	Sister	Brother
Diabetes	Mother	Father	Grandmother	Grandfather	Sister	Brother
Thyroid Disorder	Mother	Father	Grandmother	Grandfather	Sister	Brother
Cancer	Mother	Father	Grandmother	Grandfather	Sister	Brother

Relationship Status: Married Partner Single Widowed Divorced Separated Other

Do you currently smoke ?: Y N **Past smoker ?: Y N** **Do you drink alcohol ?: Y N**

Occupation: Retired Working Disabled Student Unemployed Other

Do you currently drive ?: Y N **Are you pregnant or nursing ?: Y N**

Pharmacy Name and Phone #: _____

Patient Signature: _____ Date: _____