premier VISION CLINIC

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Health History

Note that the available options for marital status, race and ethnicity are the options required by the US Government. They also include Latino/Hispanic heritage under ethnicity and consider it independent of race.

When you are finished please return to the front desk.

Patient Information:

Name: _____ Nickname: _____
Title First Last MI Suffix

Address: _____

_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

Email: _____

Preferred Contact by: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Other Phone ☐ Email ☐ Text

Date of Birth: ____/____/____

Sex: ☐ Female ☐ Male

Marital Status: ☐ Never Married ☐ Married ☐ Domestic Partner ☐ Polygamous
☐ Divorced ☐ Annulled ☐ Legally Separated ☐ Widowed

Employment Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired

Occupation/Grade: _____

Employer/School: _____

Parent/Guardian: _____

Race: ☐ Black/African American ☐ Asian ☐ White ☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaska Native ☐ Other: _____ ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Declined

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Chinese
☐ Arabic ☐ Russian ☐ Declined

General Medical History:

Primary physician's name and phone: _____

When was your last physical? _____/_____/_____

What is your preferred pharmacy name and location? _____

Check the box for any condition that apply to you, your parent or your siblings:

	No	You	Mom	Dad	Sib	Describe (type, when were you diagnosed, etc)
Hypertension	☐	☐	☐	☐	☐	_____
Thyroid	☐	☐	☐	☐	☐	_____
Cardiovascular	☐	☐	☐	☐	☐	_____
Cancer	☐	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	☐	_____

If ***You*** are diabetic, when were you diagnosed? _____ Last A1c level? _____

Height: _____ft _____in Weight: _____lbs

Are you Pregnant or Nursing? ☐ No ☐ Unsure ☐ Pregnant ☐ Nursing

List ALL major injuries or surgeries you have had and approximate dates:

_____

_____

List any other medical conditions you have had, including non-drug allergies:

_____

_____

List ALL prescription and over the counter medications (including VITAMINS) you currently take:

_____

_____

_____

_____

List any drug allergies you have:

_____

Smoking Status: ☐ Never smoker (<100 cig) ☐ Former smoker ☐ Current some day smoker ☐ Light smoker ☐ Heavy smoker ☐ Current smoker ☐ Current everyday smoker ☐ Unknown

Alcohol Use: ☐ No ☐ Yes ☐ Occasionally ☐ Socially ☐ 1 drink a day ☐ Multiple drinks a day

Do you live alone? ☐ No ☐ Yes ☐ Assisted living ☐ Nursing home

Review of Systems:

Please select any problems you are currently having anywhere, from head to toe:

General:
☐ Good
☐ Fever
☐ Fatigue
☐ Loss of Appetite
☐ Weight Gain
☐ Weight Loss
☐ Other: _____

Ear, Nose, Throat:
☐ None
☐ Congestion
☐ Dry Mouth
☐ Hearing Problems
☐ Ringing in Ears
☐ Sinus Problems
☐ Sleep Apena
☐ Snoring
☐ Other: _____

Cardiovascular:
☐ None
☐ AFib
☐ Cardiovascular Event
☐ HTN
☐ TIAs
☐ Other: _____

Respiratory:
☐ None
☐ Asthma
☐ Congestion
☐ COPD
☐ Shortness of Breath
☐ Other: _____

Genital, Kidney, Bladder:
☐ None
☐ Frequent Urination
☐ Dialysis
☐ Other: _____

Gastrointestinal:
☐ None
☐ Acid Reflux
☐ Celiac
☐ Chron's
☐ IBS
☐ Ulcers
☐ Upset Stomach
☐ Other: _____

Endocrine:
☐ None
☐ Diabetes, Type 1 or 2
☐ Hypothyroid
☐ Hyperthyroid
☐ Graves
☐ Menopause
☐ Other: _____

Muscles, Bones, Joints:
☐ None
☐ Arthritis
☐ Joint Pain
☐ Swelling
☐ Other: _____

Skin:
☐ None
☐ Acne
☐ Cancer
☐ Eczema
☐ Psoriasis
☐ Other: _____

Neurological:
☐ None
☐ Dementia
☐ Muscle Weakness
☐ Multiple Sclerosis
☐ Numberness/Tingling
☐ Seizures
☐ Stroke
☐ Vertigo
☐ Other: _____

Psychiatric:
☐ None
☐ Anxiety
☐ ADHD
☐ Depression
☐ Other: _____

Blood/Lymph:
☐ None
☐ Anemia
☐ Bleeding Disorder
☐ Other: _____

Allergy/Immune:
☐ None
☐ Seasonal Allergies
☐ Other Allergies
☐ Other Autoimmune Disorder: _____

Ocular History:

Who was your last previous eye doctor? _____

When was your last eye exam? _____/_____/_____

Check the box for any condition that apply to you, your parent or your siblings:

	No	You	Mom	Dad	Sib	Describe (type, when were you diagnosed, etc)
Glaucoma	☐	☐	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	☐	☐	_____
Retinal Problems	☐	☐	☐	☐	☐	_____
Cataracts	☐	☐	☐	☐	☐	_____
Lazy Eye/Eye Turn	☐	☐	☐	☐	☐	_____

List any eye injuries, infections, or surgeries you have had and approximate dates:

_____

_____

List any other significant eye problems you have had:

_____

_____

List ALL prescription and over the counter eye medications you currently use:

_____

_____

List any vision complaints you are currently having such as:

- blurred vision, headaches, eyestrain, double vision, or losing your place when reading
- itching, burning, redness, pain, sensitivity to light, watering, crusting or mucus discharge
- seeing rainbows around white lights at night, flashes of light or dark spots/squiggles/webs

_____

_____

How many hours a day do you typically spend using a computer or other digital devices? _____

If you are having complaints with computer work, how far is the monitor from your eyes? _____

How many hours a day do you typically spend reading books, magazines, etc.? _____

What are your hobbies/sports? _____

Do you have sunglasses? Y / N Do you have backup glasses? Y / N

Are you interested in contact lenses? Y / N

Contact Lens Wearers Only

What disinfecting solution do you use? _____ How old is your current pair of lenses? _____

How often do you replace your lenses? _____ How long do you usually wear your lenses? _____