20/20 EYECARE PROFESSIONALS

PATIENT HISTORY

TODAY'S DATE_____FULL NAME_____NICK NAME_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____ WORK_____ CELL_____

DATE OF BIRTH_____ E-MAIL ADDRESS_____ OCCUPATION_____

EMPLOYER_____ REFFERRED BY_____

GUARDIAN IF UNDER 18_____ PRIMARY CARE PHYSICIAN_____

PHONE NUMBER_____ ADDRESS_____

VISION COVERAGE_____ MEDICAL COVERAGE_____

MEDICAL INFORMATION: (if exact dates are unknown, please approximate)

Any problems with your general health? Y__ N__ Explain _____

Do you take medications or are having problems in any of these areas? **(Please circle yes or no)**

Gastrointestinal. Yes No Nervous Yes No Endocrine(glands) Yes No
Ears/Nose/Throat Yes No Urinary Yes No Blood/Lymph Yes No
Cardiovascular Yes No Muscle/Bones Yes No Allergic/Immunologic Yes No
Respiratory Yes No Skin Yes No Headaches Yes No
High blood pressure Yes No Eyes Yes No Mental health Yes No Explain-(ie,Psychiatric; anxiety,depression,insomnia)_____
Diabetes Yes No Type_____ Date of Diagnosis_____Allergies to medication Yes No
What medication(s)_____Reaction(s)_____
Other health concerns? Explain:_____
Current medication(s)_____For_____

FAMILY HISTORY

High blood pressure Yes No Relation_____Macular degeneration Yes No Relation_____
Diabetes Yes No Relation_____Retinal detachment Yes No Relation_____
Glaucoma Yes No Relation_____Cataracts Yes No Relation_____
Other family health or eye problems Yes No Explain_____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? Yes No What kind?_____
Have you had any eye operations? Yes No
Type_____Date_____
Have you had an eye injury? Yes No Type of injury_____
Date it happened (approximate if can't remember exact)_____
Do you have glaucoma? Yes No Cataracts? Yes No Dry eye? Yes No
Macular Degeneration? Yes No Retinal Detachment? Yes No Blurred vision? Yes No
Do you wear glasses? Yes No Contact lenses? Yes No Type/kind_____
Are you interested in New glasses, Contact lenses, or Laser surgery Yes No Maybe
Reason for interest_____
Are there any eye care or eyewear concerns you would like to discuss with the Doctor? Yes No
Explain_____
Interests that require special vision needs (ie Sports, Hobbies, Social events/activities_____
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PHYSICIANS SIGNATURE_____ DATE_____