

PATIENT HEALTH HISTORY

Patient Name _____ Date of Birth ___/___/___ Date ___/___/___

Patient Address _____ City _____ State _____ Zip _____

Patient Home Phone # () _____ Cell Phone # () _____ Work Phone # () _____

Patient Email address _____

Marital Status (circle one): Single Married Divorced Legally Separated Widowed

Employment Status(circle one): : Employed FT Employed PT Self Employed Student FT or PT Not Employed Retired

Employer _____ Occupation _____

Health Insurance: _____ Vision Insurance: _____

Primary Care Physician: _____ Date Last Seen by PCP: _____

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy): _____

List all major surgeries (Eye Surgery included): _____

List allergic conditions :(e.g. medications, seasonal, mold, dust, latex, eye drops): _____

Please indicate if any of the conditions apply to YOU or a FAMILY member (blood relatives only).

Disease/Condition	Relationship (Blood Relatives Only)
<input type="checkbox"/> Blindness	_____
<input type="checkbox"/> Cataract	_____
<input type="checkbox"/> Eye Turn	_____
<input type="checkbox"/> Glaucoma	_____
<input type="checkbox"/> Macular Degeneration	_____
<input type="checkbox"/> Retinal Detachment	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> Kidney	_____
<input type="checkbox"/> Lupus	_____
<input type="checkbox"/> Thyroid	_____
<input type="checkbox"/> Other	_____

Women are you pregnant? Yes, _____ weeks/months along No Are you breast feeding? Yes No

Review of Systems

Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic

- None
- Lupus (SLE)
- Rheumatoid Arthritis
- Environmental Allergies
- Other _____

Cardiovascular None

- High Blood Pressure
- Elevated Cholesterol
- Heart Disease
- Stroke
- Vascular Disease

Hematologic/Lymphatic

- None
- Anemia
- Leukemia
- Bleeding Disorder
- Other _____

Ear, Nose and Throat

- None
- Sinusitis
- Upper Respiratory Tract Infection
- Other _____

Endocrine/Glands

- None
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction
- Other _____

Neurological

- None
- Multiple Sclerosis
- Epilepsy
- Tremors
- Other _____

Gastrointestinal

- None
- Crohn's Disease
- Colitis
- Acid Reflux/Ulcer
- Other _____

Respiratory

- None
- Asthma
- Bronchitis
- Emphysema
- Other _____

General Health

- None
- Weight loss/gain
- Fever
- Fatigue
- Trauma

Skin

- None
- Eczema
- Rosacea
- Psoriasis
- Other _____

Muscle/Skeletal

- None
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Other _____

Social History

- Tobacco Use:** Current Past Smoker Never _____ cigarettes/packs per day/wk/month for _____ yrs
- Alcohol Use:** _____ drinks daily/weekly/monthly for _____ yrs
- Non-Prescription Drugs _____
- Weight** _____ **Height** _____

Psychiatric

- None
- Depression
- Bi-Polar
- Schizophrenia
- Other _____

Genital/Urinary

- None
- Urinary Tract Infection
- HIV Positive
- Herpes/Chlamydia
- Other _____

PATIENT OCULAR HISTORY

Date of last eye examination: _____ By Whom: _____

Current eye drops: Rewetting for Contact Lenses Allergy Eye Drops OTC Lubricating Drops Rx Drop(s) _____

Eye History

Please check off any current conditions you suffer from:

- | | |
|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Glare/Light Sensitivity | <input type="checkbox"/> Mucous Discharge |
| <input type="checkbox"/> Tired Eyes | <input type="checkbox"/> Drooping eyelid(s) |
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Sandy or Gritty Feeling |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Strabismus (crossed eye) |
| <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Blurred Vision at Distance |
| <input type="checkbox"/> Eye Pain and/or Soreness | <input type="checkbox"/> Blurred Vision at Near |
| <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Haloes |
| <input type="checkbox"/> Infection of Eye or Lid | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Floaters or Spots | <input type="checkbox"/> Fluctuating Vision |
| <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Loss of Side Vision |

List all YOUR current or past eye diseases, eye injuries or eye surgeries:

- | | |
|---|--|
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Dry Eye Disease |
| <input type="checkbox"/> Eye Turn | <input type="checkbox"/> Diabetic Retinopathy |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lasik (Year _____) |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Cataract Surgery (Year _____) |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Other _____ |

Contact Lens History (Skip to next section if you don't wear contacts)

What brand of contact lenses do you wear? Acuvue Oasys Acuvue Advance Air Optix Focus Dailies Purevision Other _____

How old are your current lenses? _____

How often do you replace or dispose your contact lenses? 4 weeks 3 weeks 2 weeks Daily Other _____

What brand of solution do you soak your lenses in? Optifree Clear Care Revitalens Aquify Generic brand Other _____

What is your typical wearing schedule? Every day Week days Weekends only Sports Other _____

How many hours during the day do you wear your contacts? 8 hours 10 – 12 hours 14-16 hours Other _____

How often do you nap or sleep in your contacts? Once a month/week Few times a month/week Often In the past Other _____

Please check off all that apply to you

- I am having problems with my current contact lenses: Comfort Vision
 There are times when I would rather not be wearing contact lenses
 I don't have a pair of glasses

My signature below verifies that I have received a copy of the Mark L. Bottelson, OD & Associates., P.C. Notice of Privacy Practices.

Name of Patient (Print): _____ Signature: _____

Signed by: Self Parent Legal Guardian Other: _____ Date: _____