Desert EyeCare Center

Patient Health Information

EYE HEALTH HISTORY

Patient Name: _____
First MI Last

What is the primary reason for your visit today?:

☐ Check my prescription for glasses or contacts **(will be billed using VISION insurance)**

☐ Any other reason (dry eye, itchy eyes, red eyes, floaters, etc) **(will be billed using MEDICAL insurance)**

Do you have any of the following symptoms?

☐ Blurry Vision ☐ Eye Discharge ☐ Dry Eyes ☐ Watery Eyes ☐ Spots/Floaters

☐ Burning Eyes ☐ Red Eyes ☐ Eye Pain ☐ Itchy Eyes ☐ Flashes of Light

If you are a new patient when was your last eye exam? _____

Are you interested in contact lenses: ☐ Y ☐ N

Do you currently wear contact lenses? ☐ Y ☐ N

Do you currently wear glasses? ☐ Y ☐ N

Do you currently have or have you been diagnosed with any of the following?

☐ Cataracts ☐ Diabetic Eye Disease ☐ Other Eye Disease _____

☐ Glaucoma ☐ Retinal Detachment

☐ Macular Degeneration ☐ Crossed eye/lazy eye

Have you had any eye surgeries? ☐ Y ☐ N if yes, describe _____

Have you ever had any eye injuries? ☐ Y ☐ N if yes, describe _____

Are you taking any eye medications? ☐ Y ☐ N if yes, describe _____

Have your parents, grandparents, or siblings had any of the following?

☐ Glaucoma ☐ Macular Degeneration ☐ Crossed eye/lazy eye

☐ Blindness ☐ Retinal Detachment ☐ Cataracts (cloudy lens/requires surgery)

MEDICAL HISTORY

Name of Primary Care Physician: _____ Last visit: _____

Do you take any medications? ☐ Y ☐ N if yes, please list _____

_____

Are you allergic to any medications? ☐ Y ☐ N if yes, please list_____

List all major injuries, surgeries, and/or hospitalizations: _____

Are you pregnant? ☐ Y ☐ N Are you nursing? ☐ Y ☐ N

SOCIAL HISTORY (strictly confidential)

Do you smoke? ☐ Never ☐ Currently Smoke ☐ Quit

Do you drink alcohol? ☐ No ☐ Occasionally/Socially ☐ Frequently

Do you use illegal drugs? ☐ Y ☐ N

VISUAL LIFESTYLE

What hobbies or activities do you do regularly? (ex: sewing, reading, golf, etc.)

_____

Do you use a computer more than 6 hours per day? ☐ Y ☐ N

Do you regularly experience eyestrain/fatigue, headaches/neck aches while on the computer/reading? ☐ Y ☐ N

Do you wear sunglasses while outdoors? ☐ Y ☐ N

HEALTH HISTORY

Do you have any of the following? (you MUST mark none if appropriate)

General
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Other_____
- ☐ None

Ear/Nose/Throat
- ☐ Sinus
- ☐ Dry Mouth/Dry Throat
- ☐ Cough
- ☐ Other_____
- ☐ None

Cardiovascular
- ☐ **High Blood Pressure**
- ☐ Heart Surgery
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Other_____
- ☐ None

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Other_____
- ☐ None

Genital/Kidney/Bladder
- ☐ Urinary Tract Infection
- ☐ Kidney Stones
- ☐ STD
- ☐ Other_____
- ☐ None

Muscles/Joints/Bones
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Joint/Muscle Pain
- ☐ Other_____
- ☐ None

Skin
- ☐ Acne
- ☐ Eczema
- ☐ Rosacea
- ☐ Other_____
- ☐ None

Neurologic
- ☐ Migraines
- ☐ Headaches
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Other_____
- ☐ None

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Other_____
- ☐ None

Endocrine
- ☐ Thyroid Dysfunction
- ☐ **Diabetes**
- ☐ Hormone Dysfunction
- ☐ Other_____
- ☐ None

Blood/Lymph
- ☐ Anemia
- ☐ Leukemia
- ☐ Bleeding disorder
- ☐ **High Cholesterol**
- ☐ Other_____
- ☐ None

Allergic/Immunologic
- ☐ **Seasonal Allergies**
- ☐ Lupus
- ☐ AIDS/HIV
- ☐ Other_____
- ☐ None

Gastrointestinal
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Hepatitis
- ☐ Other_____
- ☐ None

Any other condition not listed above: _____

Have your parents, grandparents, or siblings had any of the following?

☐ Cancer ☐ High Blood Pressure

☐ Diabetes ☐ Heart Disease

HIPAA NOTICE AND ACKNOWLEDGMENT

I have been presented a copy of the Privacy Practices and have been offered a copy for my records.

Printed Name: _____

Signature: _____

CONSENT TO TREAT

I hereby give my consent to Desert EyeCare Center to provide eye care services to myself and/or family.

Signature: _____