Palos Verdes Family Vision Optometry

Patient History Form

Patient Name:_____ **Date of Birth:** _____

Date of last vision examination (if elsewhere): _____

Do you have any specific questions for your doctor today? _____

Contact Lens History:

If you are not a contact lens wearer, are you interested in trying contacts today? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No Hours per day: _____ Days per week: _____

Brand or prescription you are currently wearing? _____ Today's wear time: _____ Solution: _____

If not wearing contacts now, have you tried them in the past? ☐ Yes ☐ No Reason for stopping? _____

Glasses History:

Are you planning to get new eyeglasses today? ☐ Yes ☐ No

Do you currently wear glasses? ☐ Yes ☐ No ☐ Part-time ☐ Full-time ☐ Distance ☐ Near

Glasses being worn now: ☐ Single Vision ☐ Bifocals ☐ Progressive ☐ Trifocals

Do you wear sunglasses? ☐ Yes ☐ No

Are your sunglasses your most recent prescription? ☐ Yes ☐ No

Are you interested in learning more about Laser Vision Correction? ☐ Yes ☐ No

Special Eyewear Needs:

☐ Computer (special prescriptions, anti-glare tints or coatings) ☐ Safety Glasses (gardening, woodworking, welding)

☐ Occupational (mechanics, plumbers, pilots) ☐ Sports / Hobbies (racket sports, motorcycle)

Social History:

On average, how many hours do you spend on the computer each day? _____

Do you have any hobbies and/or special interests? _____

Use of Alcohol: ☐ None ☐ Social use only ☐ 1-2 drinks daily ☐ Above average use ☐ Alcohol dependent

Use of Tobacco: ☐ None ☐ Former smoker ☐ Light smoker ☐ Average smoker ☐ Heavy smoker ☐ Chew

Use of Recreational Drugs: ☐ None Type & Frequency: _____

Sexually Transmitted Disease: ☐ None ☐ Yes ☐ HIV Positive

Current Medications

1.	_____	for	_____	6.	_____	for	_____
2.	_____	for	_____	7.	_____	for	_____
3.	_____	for	_____	8.	_____	for	_____
4.	_____	for	_____	9.	_____	for	_____
5.	_____	for	_____	10.	_____	for	_____

Ocular Medications (including over-the-counter meds/drops): _____

_____

Drug Allergies: ☐ Yes ☐ No Please List: _____

OVER> > >

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Family Physician Name: _____ City: _____ Phone: _____

Eye Symptoms/ Conditions		
☐ Headaches	☐ Excess Tearing/Watering	☐ Blurred Distance Vision
☐ Glare/Light Sensitivity	☐ Eye Pain/Soreness	☐ Blurred Near Vision
☐ Tired Eyes	☐ Sandy/Gritty Feeling	☐ Fluctuating Vision
☐ Amblyopia/Lazy Eye	☐ Foreign Body Sensation	☐ Glaucoma
☐ Burning	☐ Mucous Discharge	☐ Cataracts
☐ Dryness	☐ Double Vision	☐ Retinal Detachment
☐ Itching	☐ Intermittent Vision Loss	☐ Macular Degeneration
☐ Redness	☐ Floaters/Spots	☐ Eye Injury or Surgery
Indicate any personal history below:		
Cardiovascular	**Integumentary**	**Musculoskeletal**
☐ Heart Disease	☐ Acne Rosacea	☐ Arthritis
☐ Cholesterol, Elevated	☐ Lupus	☐ Rheumatoid Arthritis
☐ High Blood Pressure (Hypertension)	☐ Psoriasis	**Neurological**
☐ Stroke	**Head/ ENT/ Dental**	☐ Bell's Palsy
Endocrine	☐ Chronic Cough	☐ Brain Tumor
☐ Diabetes	☐ Migraines	☐ Multiple Sclerosis
☐ Gout	☐ Sinusitis	☐ Parkinson's Disease
☐ Hypo/Hyperthyroidism	☐ Dizziness	☐ Seizures
☐ Renal Disorder (Kidney)	☐ Allergies	**Psychiatric**
Gastrointestinal	**Hematologic/ Lymphatic**	☐ Alzheimer's
☐ Colitis	☐ Leukemia	☐ Bi-Polar Disorder
☐ Hepatitis	☐ Lymphatic Disorder	☐ Depression
☐ Inflammatory Bowel Disease	☐ Sickle Cell Disease	☐ Learning Disability
Genitourinary	☐ Temporal Arteritis	☐ Schizophrenia
☐ Menopause	**Immunologic**	**Respiratory**
☐ Breast Cancer (Diagnosis year:_____)	☐ AIDS	☐ Asthma
☐ Pregnant or Nursing	☐ Sarcoidosis	☐ COPD
Other	☐ Sjogren's Syndrome	☐ Emphysema
☐ Cancer (Type): _____	☐ Syphillis	☐ Lung Disease
☐ Other: _____	☐ Tuberculosis	☐ Lung Cancer (Diagnosis year:_____)

Family History:			
	Relationship to Patient		Relationship to Patient
☐ Amblyopia/Lazy Eye		☐ Cancer Type: _____	
☐ Blindness		☐ Diabetes	
☐ Cataracts		☐ Heart Disease	
☐ Glaucoma		☐ Stroke	
☐ Retinal Detachment		☐ Thyroid Disease	
☐ Macular Degeneration		☐ High Blood Pressure	