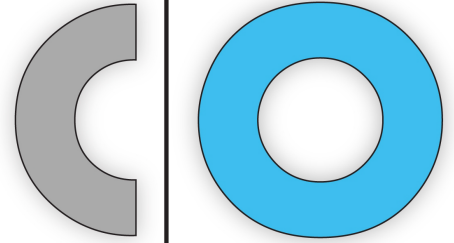


# Patient History Form

---



Reason for examintaion today:

Do you wear contacts/Are you interested in contacts?

Are you interested in Lasik?

List all current illnesses, injuries, or recent surgery:

List all current medications you are taking:

Allergies to medications:

Other known Allergies:

## Visual symptoms, please check all that apply to you:

- |                          |                            |                          |                          |
|--------------------------|----------------------------|--------------------------|--------------------------|
| <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"/> | Ptosis (Drooping Eyelid) |
| <input type="checkbox"/> | Burning                    | <input type="checkbox"/> | Redness                  |
| <input type="checkbox"/> | Dryness                    | <input type="checkbox"/> | Blurred Vision Distance  |
| <input type="checkbox"/> | Excessive Tearing/Watering | <input type="checkbox"/> | Blurred Vision Near      |
| <input type="checkbox"/> | Eye pain or Soreness       | <input type="checkbox"/> | Distorted Vision (halos) |
| <input type="checkbox"/> | Foreign Body Sensation     | <input type="checkbox"/> | Double Vision            |
| <input type="checkbox"/> | Infection of the Eye       | <input type="checkbox"/> | Floaters or Spots        |
| <input type="checkbox"/> | Loss of Vision             |                          |                          |

## Ocular Medical and Family Medical History, please check all that apply to you:

Yourself	Family Member		Family member's relation to you
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems (asthma, emphysema, etc.)	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Genital, Kidney, Bladder	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Skin (acne, warts, skin cancer, etc.)	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Neurological (Multiple Sclerosis, etc.)	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric (anxiety, depression, insomnia)	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic (hay fever, lupus, etc.)	<input type="checkbox"/>

**Ocular Medical and Family Medical History, please check all that apply to you:**

Yourself	Family Member		Family member's relation to you
_____	_____	Amblyopia (lazy eye)	_____
_____	_____	Blindness	_____
_____	_____	Cataracts	_____
_____	_____	Color Blindness	_____
_____	_____	Glaucoma	_____
_____	_____	Macular Degeneration	_____
_____	_____	Retinal Detachment	_____
_____	_____	Strabismus (eye turn)	_____
_____	_____	Arthritis	_____
_____	_____	Cancer	_____
_____	_____	Diabetes	_____
_____	_____	Heart Disease	_____
_____	_____	High Blood Pressure	_____
_____	_____	Kidney Disease	_____
_____	_____	Lupus	_____
_____	_____	Stroke	_____
_____	_____	Thyroid Disease	_____
_____	_____	Other	_____

Have you been exposed to any of the following diseases?:

HIV:       Herpes Simplex:   
 Syphilis:       Chlamydia:

Do you use a computer?: Yes  No   
 Frequency?: \_\_\_\_\_

Do you drive?: Yes  No

Do you have difficulty seeing while driving?: Yes  No

Do you drink alcohol?: Yes  No   
 Frequency?: \_\_\_\_\_

Do you smoke?: Yes  No   
 Frequency?: \_\_\_\_\_

Have you worn contacts in the past?: Yes  No

Are you currently wearing contacts?: Yes  No   
 If yes, what brand/type of contact lenses?:  
 \_\_\_\_\_

**Please Note:** Contact lens services/measurements are not included in a comprehensive eye exam. A comprehensive eye exam includes a full eye health check with glaucoma testing, visual field screening, refraction, and dialation as necessary. **Our contact lens diagnostic evaluation and fitting fees range from \$65 to \$115 depending on your history with contact lenses and the type of contact lenses you are prescribed.**

I would like a contact lens evaluation and prescription today.: Yes  No

**Acknowledgement of Receipt of Privacy Notice:**

I acknowledge that I have been offered a copy of Dr. Jeffrey Holland's Notice of Privacy Practices. I have accepted the notice or declined to accept the notice.

Your Name (print)

Signature of Patient or authorized representative

\_\_\_\_\_

\_\_\_\_\_

Date