Lakeside Family Eyecare Health History

General Information Date _____

Last Name _____ First Name _____ MI_____

DOB _____ Male or Female Marital Status: Married / Single / Divorced / Widowed

Address _____

Primary phone # _____ Secondary phone # _____

Email _____ Sports/Hobbies _____

Employer/School _____ Occupation/Grade _____

Emergency Contact _____ Relation _____ Phone # _____

HISTORY

Date of last medical exam _____ Primary Physician/Clinic _____

Date of last eye exam _____ Clinic/Doctor's Name _____

Do you wear glasses Yes No All the time / Sometimes / Work / Reading / Driving

Do you wear contacts Yes No Contact Brand _____

Have you ever:

- Had eye injury Yes No Describe _____
- Had eye surgery Yes No Describe _____
- Used eye medication Yes No Describe _____

Have you ever been diagnosed with

- Cataracts Yes No When _____
- Glaucoma Yes No When _____
- Macular Degeneration Yes No When _____

Are you nursing/pregnant? Yes No

Visual Symptoms – indicate right, left or both along with severity: 1(low), 2(moderate), 3(high)

[ ] Blurred distance vision	R L B	[ ] Dry eyes	R L B	[ ] Headaches	R L B
[ ] Blurred near vision	R L B	[ ] Red eyes	R L B	[ ] Poor night vision	R L B
[ ] Double vision	R L B	[ ] Watery eyes	R L B	[ ] Loss of vision	R L B
[ ] Eye strain	R L B	[ ] Wandering eye	R L B	[ ] Crossed eye(s)	R L B
[ ] Mucus discharge	R L B	[ ] Light sensitivity	R L B	[ ] Eye pain/soreness	R L B
[ ] Floaters/spots	R L B	[ ] Gritty feeling	R L B	[ ] Tired eyes	R L B
[ ] Flashes	R L B	[ ] Poor color vision	R L B	[ ] Burning eyes	R L B
[ ] Halos	R L B	[ ] Droopy lid	R L B	[ ] Itchy eyes	R L B

PERSONAL MEDICAL HISTORY: Please check any of the following that applies to you.

Cardiovascular ___None ____Hypertension ____Stroke ____Heart Disease ____Vascular Disease ____Other:	Endocrine ___None ___Non Insulin Dependent Diabetes ___Insulin Dependent Diabetes ___Thyroid Disease ___Hormone Dysfunction ___Other:	Respiratory ___None ___Asthma ___Bronchitis ___Emphysema ___COPD ___Other:
Constitutional ___None ___Cancer ___Trauma/Large Volume Loss ___Developmental Disability ___Other:	Ocular ___None ___Glaucoma ___Macular Degeneration ___Detached Retina ___Other:	Psychiatric ___None ___ADHA ___Depression ___Schizophrenia ___Other
Neurological ___None ___Multiple Sclerosis ___Epilepsy ___Cerebral Palsy ___Tumor ___Other:	Musculoskeletal ___None ___Osteoarthritis ___Fibromyalgia ___Muscular Dystrophy ___Ankylosing Spondylitis ___Other:	Immunologic ___None ___AIDS/HIV ___Rheumatoid Arthritis ___Lupus ___Neurofibromatosis ___Other:
Hematological ___None ___Anemia ___Leukemia ___Other:	Gastrointestinal ___None ___Crohn's ___Colitis ___Other	Ear/Nose/Throat ___None ___Hearing Loss ___Upper Respiratory Infection ___Other:
Dermatologic ___None ___Eczema ___Rosacea ___Psoriasis ___Other:	Allergies ___None Medications: Environmental:	Alcohol Use; Amount: Tobacco Use: Amount

Please list physical reactions to the above allergies: _____

_____

List any medications you are currently taking (including herbal):

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

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children) been diagnosed with the following:

Retinal Detachment	Yes / No _____	Blindness	Yes / No _____
High Blood Pressure	Yes / No _____	Cataracts	Yes / No _____
Crossed Eyes	Yes / No _____	Glaucoma	Yes / No _____
Macular Degen	Yes / No _____	Diabetes	Yes / No _____
Heart Disease	Yes / No _____	Cancer	Yes / No _____
Thyroid Disease	Yes / No _____	Lupus	Yes / No _____