# VISIONARY EYECARE

Health Information Form

Primary Care Physician:_____ Last Medical Exam: _____

Previous Eye Doctor: _____ Last Eye Exam: _____

- Current Vision Correction: Glasses Contacts Neither
- If not already, are you interested in wearing contact lenses? Yes No

## Patient Medical History

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Allergies | Yes | No | Gastrointestinal Disorder | Yes | No | Neurological Disorder | Yes | No |
| Arthritis | Yes | No | Glaucoma | Yes | No | Retinal Detachment | Yes | No |
| Asthma | Yes | No | Heart Attack | Yes | No | Sinus Problems | Yes | No |
| Blood Disorder | Yes | No | Heart Disease | Yes | No | Skin Disorder | Yes | No |
| Cancer | Yes | No | Hepatitis | Yes | No | STD | Yes | No |
| Cataracts | Yes | No | High Blood Pressure | Yes | No | Stroke | Yes | No |
| Cholesterol | Yes | No | HIV/AIDS | Yes | No | Thyroid Disorder | Yes | No |
| COPD | Yes | No | Kidney Disease | Yes | No | Unusual weight loss/gain | Yes | No |
| Diabetes | Yes | No | Lazy Eye | Yes | No | Other _____ | | |
| Eye Disease | Yes | No | Lupus | Yes | No | | | |
| Eye Injury | Yes | No | Macular Degeneration | Yes | No | | | |

## Family Medical History (Relation to you)

Blindness_____ Glaucoma_____ Macular Degeneration_____

Cataracts_____ Heart Disease_____ Retinal Detachment _____

Diabetes_____ Lazy Eye_____ Other _____

## Patient Information

Height:_____ Weight: _____

Medications (RX & OTC):_____

_____

_____

Major Illness or Injuries:_____

_____

_____

Surgeries (including Eyes):_____

_____

_____

Drug Allergies: None If yes, list: _____

Alcohol use: Yes No If yes, amount:_____

Tobacco use: Yes No If yes, amount:_____

Recreational Drugs/substances: Yes No

If Yes, Explain:_____

## Circle All Current Eye Related Symptoms

| | | | | |
|---|---|---|---|---|
| Blurred Vision | Eye strain | Headaches | Night blindness | Uncomfortable Contact Lenses |
| Burning | Flashes of light | Irritation | Red | Uncomfortable Glasses |
| Dizziness | Floaters/ Spots | Itching | Sore | |
| Double Vision | Glare | Light sensitivity | Sudden loss of vision | |
| Dry Eye | Gritty sensation | Nausea | Other:_____ | |

## Circle All Of Your Hobbies/ Activities

| | | | |
|---|---|---|---|
| Baseball | Computer | Needlework | Other:_____ |
| Basketball | Fishing | Piano | _____ |
| Biking | Golf | Swimming | _____ |