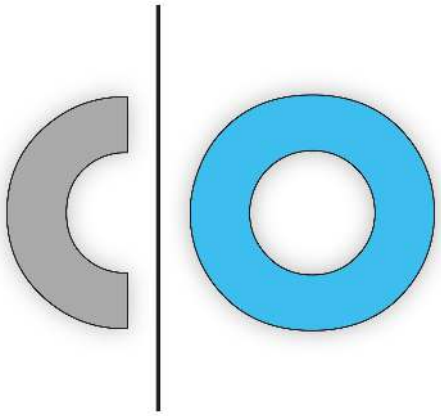
Patient History Form



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:

_____ Headaches
_____ Glare/Light Sensitivity
_____ Tired Eyes
_____ Burning
_____ Dryness
_____ Excessive Tearing/Watering
_____ Eye pain or Soreness
_____ Foreign Body Sensation
_____ Infection of the Eye
_____ Loss of Vision

_____ Itching
_____ Mucous Discharge
_____ Ptosis (Drooping Eyelid)
_____ Redness
_____ Blurred Vision Distance
_____ Blurred Vision Near
_____ Distorted Vision (halos)
_____ Double Vision
_____ Floaters or Spots

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

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

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