ANTIOCH EYE ASSOCIATES HEALTH AND HISTORY FORM

First Name ________________________ Middle ________________ Last ___________________________

Preferred Name ____________________ Gender Male / Female Date of Birth ______________________

Street Address____

City __________________________________ State _______________ Zip Code ______________________

Primary Phone _______________________ Home / Cell Text OK? Y / N Leave message? Y / N

Secondary Phone _____________________ Home / Cell Text OK? Y / N Leave message? Y / N

Email: ____

Preferred contact method: Phone / Email /Mail

Preferred Language: English / Spanish / Other __________________

Marital Status: Single / Married / Divorced / Separated / Widowed

Race: African American / Asian / Hispanic / White / Other (specify) ______________________________

Ethnicity: Hispanic or Latino /Not Hispanic or Latino

Hobbies: ____

Reason for your visit: Exam /Glasses / Contacts / Eye Infection / Injury / LASIK consult / Other

Date of last eye exam: _________________How old are your current glasses: ________________________

Are you planning to get new glasses on this visit: Yes /No / If necessary

Contact lens brand wearing: ______________________________ Solution using: ______________________

How often do you change your lenses: _______________________ Do you sleep in your contacts: Yes / No

Primary Care Physician: _______________________________ Date of last physical: ____________________

List of all current medications and reason for taking (include prescription, over-the-counter, and supplements):

____

____

Allergies to medication: Yes / No If yes, please list: ____

Environmental allergies: Yes / No If yes, please list: ____

I acknowledge that I received a copy of the HIPAA privacy policy for Antioch Eye Associates. My records may be released to/discussed with–list specific name(s) and relationship (i.e. spouse, parent, child, doctor, school):

Name: ____ Relationship: ____________________________

Name: ____ Relationship: ____________________________

Name: ____ Relationship: ____________________________

Signature ____ Date: _________________________________

Relationship to patient: ____

Current Ocular History (please check or circle present issues):

Blurred vision-distance	Blurred Vision-Near	Foreign Body Sensation	Distorted Vision (halos)	Itching
Eye Infection	Burning	Redness	Swelling	Eye Pain/Soreness
Dry Eyes	Sandy/Gritty Feeling	Keratoconus	Light Sensitivity	Drooping Lid
Tired Eyes	Headaches	Amblyopia (lazy eye)	Loss of Vision	Color Blindness
Macular Degeneration	Diabetic Retinopathy	Discharge watery or mucous	New Floaters or Flashing Lights	Other:
Cataract(s)	Glaucoma	Double vision	Nystagmus	None

Social History:

Tobacco Use: Never / Former / Current
Alcohol Use: None / Social / 1-2 daily / Chemical Dependence
Narcotic Use: None / Recreational / Chemical Dependence
STD: None / Yes / HIV+
Blood Transfusion: None / Yes / HIV+

Current Health Conditions (please check or circle all that apply):

Cardiovascular
_____ Heart Disease
_____ Elevated Cholesterol
_____ Hypertension
_____ Heart Attack
_____ Stroke
Constitutional
_____ Anemia
_____ Sleep Disorder
_____ Weight loss/gain
Ear, Nose, Throat
_____ Tonsillectomy
_____ Adenoidectomy
_____ Dental Disorder
_____ Hearing Loss
_____ Sinus
Endocrine
_____ Diabetes
_____ Thyroid Disease

Gastrointestinal
_____ Colon Cancer
_____ Gall Bladder
_____ Hepatitis
_____ Ulcer
Genitourinary
_____ Kidney Stones
_____ Prostate Cancer
Hemotologic/Lymphatic
_____ Anemia
_____ Breast Cancer
Immunologic
_____ Lupus
_____ Herpes Simplex/Zoster
_____ Sjogren's
_____ Tuberculosis
Skin
_____ Acne Rosacea
_____ Dermatitis

Musculoskeletal
_____ Arthritis
_____ Down's syndrome
_____ Osteoporosis
Neurological
_____ Bell's Palsy
_____ Headaches
_____ Multiple Sclerosis
_____ Seizure Disorder
Psychiatric
_____ ADHD
_____ Alzheimer's
_____ Anxiety
_____ Depression
_____ Learning Disability
Respiratory
_____ Asthma
_____ Lung Disease
Pregnant or Nursing Yes / No

Other ____

List all major injuries, surgeries, and/or hospitalizations ________________________________

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Family History (please check or circle all that apply):

Glaucoma	Retinal detachment	High Cholesterol	Thyroid Disease	Other (specify):
Macular Degeneration	Amblyopia (lazy eye)	High Blood Pressure	Color Blindness	
Cataracts	Diabetes	Heart Disease	Stroke	
Arthritis	Cancer	Kidney Disease	None	