Crofton Family Eye Care Patient Health History and Information

Patient's Name:

Race:
- ❍ American Indian or Alaska Native
- ❍ Asian
- ❍ Black or African American
- ❍ Hispanic or Latino
- ❍ Native Hawaiian or Other Pacific Islander
- ❍ White or Caucasian
- ❍ Other Race: _____
- ❍ Decline to Specify

Ethnicity: ❍Not Hispanic or Latino ❍Hispanic or Latino ❍Decline to Specify

Preferred Language: ❍English ❍Other: _____ **Height:** _____ ft _____ in **Weight:** _____ lbs

Primary Care Physician: _____ **City/State:** _____

Pharmacy Name: _____ **City/State:** _____

Medications: list *only* those not obtained from the pharmacy above

_____

Medical Allergies: _____

Past Surgeries: _____

Eye History

❍ Yes ❍ No Glare/Light Sensitivity
❍ Yes ❍ No Headaches
❍ Yes ❍ No Tired Eyes
❍ Yes ❍ No Burning/Dryness
❍ Yes ❍ No Epiphora/Tearing
❍ Yes ❍ No Eyelid Swelling
❍ Yes ❍ No Eye Pain or Soreness
❍ Yes ❍ No Foreign Body Sensation
❍ Yes ❍ No Itching
❍ Yes ❍ No Mucous
❍ Yes ❍ No Redness
❍ Yes ❍ No Blurred Vision Distance
❍ Yes ❍ No Blurred Vision Near
❍ Yes ❍ No Distorted Vision
❍ Yes ❍ No Double Vision
❍ Yes ❍ No Flashes of Light
❍ Yes ❍ No Floaters or Spots
❍ Yes ❍ No Loss of Vision
❍ Yes ❍ No Blindness
❍ Yes ❍ No Cataract(s)
❍ Yes ❍ No Color Blindness
❍ Yes ❍ No Diabetic Retinopathy
❍ Yes ❍ No Eye Injuries
❍ Yes ❍ No Glaucoma
❍ Yes ❍ No Glaucoma Suspect
❍ Yes ❍ No Macular Degeneration
❍ Yes ❍ No PVD/Floaters
❍ Yes ❍ No Retinal Detachment
❍ Yes ❍ No Strabismus/Eye Turn
❍ Yes ❍ No Other

General Health

❍ Yes ❍ No Ear, Nose, Throat, Mouth
❍ Yes ❍ No Cardiovascular (heart, hypertension, etc.)
❍ Yes ❍ No Respiratory (asthma, emphysema, etc.)
❍ Yes ❍ No Gastrointestinal
❍ Yes ❍ No Genital, Kidney, Bladder
❍ Yes ❍ No Muscle, Bones, Joints (arthritis, etc.)
❍ Yes ❍ No Skin (rash, skin cancer, etc.)
❍ Yes ❍ No Neurologic (multiple sclerosis, etc.)
❍ Yes ❍ No Psychiatric (anxiety, depression, etc.)
❍ Yes ❍ No Endocrine (diabetes, hypothyroid, etc.)
❍ Yes ❍ No Blood/Lymph (anemia, cholesterol, etc.)
❍ Yes ❍ No Allergy/Immunologic (allergies, lupus, etc.)
❍ Yes ❍ No Pregnant/Nursing

Family History – *if yes, please indicate which family member*

❍ Yes ❍ No Blindness
❍ Yes ❍ No Cataract(s)
❍ Yes ❍ No Glaucoma
❍ Yes ❍ No Glaucoma Suspect
❍ Yes ❍ No Macular Degeneration
❍ Yes ❍ No Retinal Detachment
❍ Yes ❍ No Strabismus (Eye Turn)
❍ Yes ❍ No Arthritis
❍ Yes ❍ No Cancer
❍ Yes ❍ No Diabetes
❍ Yes ❍ No Heart Disease
❍ Yes ❍ No Hypertension
❍ Yes ❍ No Kidney Disease
❍ Yes ❍ No Lupus
❍ Yes ❍ No Stroke
❍ Yes ❍ No Thyroid Disease
❍ Yes ❍ No Other eye condition:

Social History

Occupation: _____
Do you drink alcohol? ❍ No ❍ Occasional ❍ 1 Per Day ❍ 2-3/day ❍ 4+/day
Do you smoke? ❍ No ❍ Occasional ❍ ½ pack/day ❍ 1 pack/day ❍ 1+ pack/day
Past/Former Smoker? ❍ Yes ❍ No
Do you take vitamins? ❍ Yes ❍ No
Do you use a computer? ❍ Yes ❍ No
Do you currently wear glasses? ❍ Yes ❍ No
Do you engage in regular exercise? ❍ Yes ❍ No
Do you drive? ❍ Yes ❍ No
Do you currently wear contact lenses? ❍ Yes ❍ No
Type and brand of contact lenses: