Appointment date

American Family Vision Clinc: Patient History Form

HH17-1

Last name | MI | First name

DOB | Age | ☐ Male ☐ Female | Phone | Cell

E-mail | How were you referred to us?

Mail Addr. | City | State | ZIP

Occupation (of parent if minor) | Employer | W. Phone

Spouse | Employer | W. Phone

Parents/guardians/caregivers | Accompanying adult

Reason(s) for Today's Visit ☐ Exam ☐ Glasses ☐ Contacts ☐ Eye health concern ☐ Learning/school difficulties ☐ Vision therapy eval.

Common Visual symptoms (check all that apply)

☐ Blurry vision up close ☐ Blurry vision far away ☐ Eye strain ☐ Watering eyes ☐ Itchy eyes ☐ Light sensitive

☐ Motion sickness ☐ Headaches ☐ Double vision ☐ Dry eyes ☐ Floaters ☐ Red/irritated eyes

When was your last eye exam? | Results?

Do you currently wear glasses or contacts? | For what?

Have you had any eye diseases, injuries, or surgeries? Any head or neck injuries? Please give details below.

Hobbies/sports | Computer/screen time

Medical History

Primary care physician | Do you use tobacco, alcohol, other drugs?

List your medications/supplements

Review of Systems: If a box is left unchecked, we'll assume that you do not have that condition.

Allergies/Immune system
- ☐ ***Drug allergies (list below)***
- ☐ Environmental allergies (list above)
- ☐ Rheumatoid arthritis
- ☐ Lupus

Gastrointestinal (digestive)
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive

Psychiatric
- ☐ Depression
- ☐ Anxiety/panic disorder
- ☐ Schizophrenia

Endocrine (glands)
- ☐ ***Diabetes***
- ☐ Thyroid dysfunction
- ☐ Hormonal dysfunction

Eyes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Surgeries
- ☐ Retinal detachment

Neurological (brain)
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Alzheimers
- ☐ Parkinsons
- ☐ Siezure disorder

Ear/Nose/Mouth/Throat
- ☐ Respiratory infection
- ☐ Ear ache
- ☐ Ringing/Tinitis
- ☐ Sore throat

Skin
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis

Muscular/Skeletal
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis

Constitutional
- ☐ Developmental disability
- ☐ Weight Loss
- ☐ Fever
- ☐ Fatigue

Blood/Lymphatic
- ☐ Anemia
- ☐ Blood loss
- ☐ Leukemia

Cardiovascular (heart, arteries)
- ☐ Heart disease
- ☐ ***High blood pressure***
- ☐ Stroke
- ☐ Vascular disease

Genital/Urinary
- ☐ Herpes
- ☐ Chlamydia

Respiratory (breathing)
- ☐ Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema

☐ **Cancer**

Additional info or other conditions not listed

Family History (blood relatives only, please indicate relation: mom, dad, gf, gm, ggm, aunt, etc.)

Macular degeneration | Glaucoma | Amblyopia/lazy eye | Retinal detachment | Blindness

Diabetes | Heart disease | Stroke | Cancer (and type)