

Appointment date

American Family Vision Clinic: Patient History Form

HH17-10

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 Watery 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.

<p>Allergies/Immune system</p> <p><input type="checkbox"/> <i>Drug allergies (list below)</i></p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p><input type="checkbox"/> Environmental allergies (list above)</p> <p><input type="checkbox"/> Rheumatoid arthritis</p> <p><input type="checkbox"/> Lupus</p> <p>Gastrointestinal (digestive)</p> <p><input type="checkbox"/> Crohn's</p> <p><input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> Digestive</p> <p>Psychiatric</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Anxiety/panic disorder</p> <p><input type="checkbox"/> Schizophrenia</p> <p>Endocrine (glands)</p> <p><input type="checkbox"/> <i>Diabetes</i></p> <p><input type="checkbox"/> Thyroid dysfunction</p> <p><input type="checkbox"/> Hormonal dysfunction</p>	<p>Eyes</p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Macular degeneration</p> <p><input type="checkbox"/> Surgeries</p> <p><input type="checkbox"/> Retinal detachment</p> <p>Neurological (brain)</p> <p><input type="checkbox"/> Multiple sclerosis</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Alzheimers</p> <p><input type="checkbox"/> Parkinsons</p> <p><input type="checkbox"/> Siezure disorder</p> <p>Ear/Nose/Mouth/Throat</p> <p><input type="checkbox"/> Respiratory infection</p> <p><input type="checkbox"/> Ear ache</p> <p><input type="checkbox"/> Ringing/Tinitis</p> <p><input type="checkbox"/> Sore throat</p> <p>Skin</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Rosacea</p> <p><input type="checkbox"/> Psoriasis</p>	<p>Muscular/Skeletal</p> <p><input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> Muscular Dystrophy</p> <p><input type="checkbox"/> Osteoarthritis</p> <p><input type="checkbox"/> Ankylosing Spondylitis</p> <p>Constitutional</p> <p><input type="checkbox"/> Developmental disability</p> <p><input type="checkbox"/> Weight Loss</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Fatigue</p> <p>Blood/Lymphatic</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Blood loss</p> <p><input type="checkbox"/> Leukemia</p>	<p>Cardiovascular (heart, arteries)</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> <i>High blood pressure</i></p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Vascular disease</p> <p>Genital/Urinary</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> Chlamydia</p> <p>Respiratory (breathing)</p> <p><input type="checkbox"/> Smoker</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Cancer <input type="text"/></p>
<p>Additional info or other conditions not listed</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>			

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)