Insight EYE SPECIALISTS

Patient Health History

Patient Name: _____

Date of Birth: _____

Were you referred to us by another Doctor? □ No □ Yes If yes list the Doctor Name

Eye Health History				
Have you ever had any history of eye conditions or surgery? □ **No** □ **Yes** **If yes please complete below**				
	Right	**Left**	**Both**	**Explanation**
Amblyopia				
Cataracts				
Diabetic Retinopathy				
Dry Eye				
Glaucoma				
Iritis				
Macular Degeneration (dry)				
Macular Degeneration (wet)				
Strabismus				
Trauma				
Other:				

Eye Surgical History			
Have you ever had any eye surgeries? □ **No** □ **Yes** **If yes please complete below**			
	Eye	**Date**	**Surgeon**

General Medical History		
Have you ever had any of the following major illnesses, diseases, or injuries? □ **No** □ **Yes** **If yes please complete below**		
		Explanation
Arthritis		
Asthma		
Cancer		
Diabetes		
Emphysema/COPD		
Gastrointestinal Disease		
Head or Spinal Injuries		
Heart Disease		
Hepatitis		
High Blood Pressure		
High Cholesterol		
HIV/AIDS		
Kidney Disease		
Lupus/Autoimmune Disease		
Migraines		
Neurological Disease		
Pregnancy		
Psychiatric Disorder		
Seizures, Convulsions, Fainting		
Shingles		
Skin Conditions		
Stroke		
Thyroid Conditions		
Other:		

Eye Maintenance	
	Explanation
Date of last eye exam and where	
How often do you wear glasses?	
Any problems with current glasses?	
Rx/Brand of contact lenses	
Hours per day of contact wear time	
Do you sleep in your contact lenses?	
Problems with your contact lenses?	
How often do you replace contacts?	
How old are your current contacts?	
Date of last contact lens wear	

Current Allergies
Do you have any allergies to medication or Latex? □ **No** □ **Yes** **If yes please complete below**
1.
2.
3.
4.

Current Medications
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.

Past Surgeries/Date	Date
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

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Current Review of Systems		
Do you currently have problems in the following areas? □ No □ Yes If yes please complete below		
		Explanation
GENERAL (fever, weight gain/loss, tired)		
EAR, NOSE, THROAT (earache, cough, stuffy nose)		
CARDIOVASCULAR (high blood pressure, racing pulse, chest pain)		
RESPIRATORY (congestion, wheezing, short of breath)		
GASTROINTESTINAL (diarrhea, constipation, hernia, ulcers)		
GENITAL, KIDNEY, BLADDER (painful/frequent urination, UTI's)		
FEMALES (Pregnant? Nursing?)		
MUSCLES BONES, JOINTS (stiffness, joint pain, arthritis)		
SKIN (acne, eczema, warts, rash, growths)		
NEUROLOGICAL (numbness, headache, seizures, paralysis)		
PSYCHIATRIC (anxiety, depression, insomnia)		
ENDOCRINE (diabetes, thyroid, graves)		
BLOOD/LYMPH (bleeding, high cholesterol, anemia)		
ALLERGIC/IMMUNOLOGIC (sneezing, redness, itching, lupus MS)		

Social History	
	Explanation
Occupation	
Hobbies/Activities	
Alcohol Use	

Tobacco/Smoking Status			
Check below			
Current every day user		Chews products containing tobacco	
Current some day user		Pipe Smoker	
Former tobacco user		Cigar smoker	
Never tobacco user		Vape (e-cigarette) user	
Snuff user		Hookah pipes or pens	

Family Eye History			
Is there any family history of the following eye conditions/diseases? □ No □ Yes If yes complete below			
		Family Member	**Comments**
Adopted-Unknown			
Amblyopia/Lazy Eye			
Cataracts			
Macular Degeneration			
Diabetic Retinopathy			
Glaucoma			
Retinal Disease/Detachment			
Other:			

Family Medical History			
Is there any family history of the following medical conditions/diseases? □ No □ Yes If yes complete below			
		Family Member	**Comments**
Adopted-Unknown			
Autoimmune Disorders			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Stroke			
Other:			