

YORK EYE ASSOCIATES HEALTH HISTORY

Please Print

What is the main reason for your visit today? _____

LAST EYE EXAM _____(YRS.)

Do you wear glasses? No Yes If yes, how old are your present pair of lenses? _____

Do you wear contact lenses? No Yes If yes, how old are your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? No Yes

Type of contact lens solutions (list all that apply): _____

Do you sleep in your contact lenses? No Yes Occasionally

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes

Please explain what difficulties you have: _____

Do you have any objection to dilation of the eyes? No Yes

Do YOU or does anyone in your FAMILY have any problems in the following areas?

DISEASE / CONDITION	Self	DISEASE / CONDITION	Self	Family	Additional Information
Itching / Burning / Pain	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Excessive Tearing / Watering	<input type="checkbox"/>	Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Glare / Haloes / Light Sensitivity	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Infection of Eye or Lid	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	
Flashes / Floaters in Vision	<input type="checkbox"/>	Color Blindness / Blindness	<input type="checkbox"/>	<input type="checkbox"/>	
Mucous Discharge	<input type="checkbox"/>	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	
Sandy / Gritty Feeling	<input type="checkbox"/>	Previous Eye Injury / Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Blurred / Dim / Double Vision	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	
Tired / Strained Eyes	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	
Dryness / Redness	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	

Please list any additional symptoms or problems regarding your eyes: _____

MEDICATIONS: Please list all prescription medications or over the counter medications you are presently taking.

Name of Medication	Dosage	Date Started	Action of Drug

Do you have any allergies to medications? No Yes If yes, please explain: _____

Primary Care Physician Name: _____ **Phone Number:** _____

Are you under the care of any other physicians? Please list _____

Do YOU or does anyone in your FAMILY have any problems in the following areas?

DISEASE / CONDITION	Self	Family (Please Specify)	Please list any associated SURGERIES, hospitalizations and/or additional information:
CONSTITUTIONAL Fever / Weight Gain or Loss	<input type="checkbox"/>	<input type="checkbox"/>	
SKIN DISORDERS Eczema / Psoriasis Acne / Acne Rosacea	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
CANCER Type _____	<input type="checkbox"/>	<input type="checkbox"/>	
VASCULAR / CARDIOVASCULAR DIABETES I or II (circle one) Heart Pain / Heart Problems / Stroke High Blood Pressure / Low Blood Pressure Vascular disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
NEUROLOGICAL Headaches / Migraines / Dizziness Seizures Multiple Sclerosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
GASTROINTESTINAL Diarrhea / Constipation Stomach Disease / Intestinal Disease Ulcers / Liver Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
GENITOURINARY Genitals / Bladder / Kidney Disease Prostate	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
EARS, NOSE, MOUTH, THROAT Allergies / Hay Fever / Sinus Congestion Chronic Cough / Dry Throat or Mouth	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
LYMPHATIC / HEMATOLOGICAL Anemia Blood Disorders Type _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
ENDOCRINE Thyroid - Hyper or Hypo (circle one) Other gland disorders	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
PSYCHIATRIC (Depression, anxiety, fears, phobias, psychoses or mental problems)	<input type="checkbox"/>	<input type="checkbox"/>	
RESPIRATORY Asthma / Bronchitis / Emphysema Tuberculosis / Other Lung Problems Sleep Apnea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
BONES / JOINTS / MUSCLE Arthritis Type _____ Lupus Rheumatoid Muscle Pain / Joint Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Social History	Yes	NO	If yes, please explain:
Do you drink alcohol, smoke or use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been exposed to or infected with: Gonorrhea / Hepatitis / HIV/ Syphilis / Herpes	<input type="checkbox"/>	<input type="checkbox"/>	
Are you pregnant and / or nursing?	<input type="checkbox"/>	<input type="checkbox"/>	
Are there any other problems or syndromes (congenital or acquired)?	<input type="checkbox"/>	<input type="checkbox"/>	

I certify that the above information is true and correct to the best of my knowledge.

Patient or Guardian Signature _____ Date _____

Doctor Signature _____ OD Date _____

*** Please make sure you have completed both sides of this form***