Vision Haus
OPTOMETRY

Last Name:___________________________ **First Name:**________________________ **MI:**__ **DOB:**___/___/____
Occupation / Hobbies:________________________________ **Physician / Clinic:**___________________________
Reason For Today's Visit:

Tobacco: Yes / No Chew / Cigarettes
For how long:________________________
If you quit how many years ago?_________

Alcohol: Yes / No Beer / Wine / Hard Liquor
For how long:_______________________________
Recreation drug use:__________________________

Medications and/or Vitamins that the Patient is taking:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Medical Allergies:____
Primary Vision Correction: **Glasses / Contacts / None**
Type of Contacts Worn in the Past:____
Wear time:_________________ **Cleaning solution:**____

Medical History of Patient: **Height**_______ **Weight**_______

General: Fever/ Weight Loss/ Weight Gain/ Fatigue/ Other____________________ **NONE**
Ear, Nose, Throat: Allergies/ Sinus/ Cough/ Dry Mouth/ Other________________ **NONE**
Cardiovascular: Hypertension/ Heart Disease/ Vascular Disease/ Other____________ **NONE**
Respiratory: Asthma/ Bronchitis/ Emphysema/ COPT/ Other _____________ **NONE**
Genital, Kidney, Bladder: Kidney Stones/ Frequent Urination, Impotence/ Other_________ **NONE**
Musculoskeletal: Osteoarthritis/ Fibromyalgia/ Muscular Dystrophy/ Other ____________ **NONE**
Dermatologic: Eczema/ Rosacea/ Psoriasis/ Other _____________ **NONE**
Neurological: Multiple Sclerosis/ Epilepsy/ Cerebral Palsy/ Tumor/ Stroke/ Other ___________ **NONE**
Headaches/ Migraines/ Seizures
Psychiatric: ADHD/ Depression/ Schizophrenia/ Anxiety/ Other ____________ **NONE**
Endocrine: Type 1 Diabetes/ Type 2 Diabetes/ Thyroid Problem/ Other_____________ **NONE**
Constitutional: Cancer/ Trauma/ Developmental Disability/ Other ___________ **NONE**
Ocular: Glaucoma/ Macular Degeneration/ Detached Retina/ Other____________ **NONE**
Immunological: AIDS/ HIV/ Rheumatoid Arthritis/ Lupus/ Other ____________ **NONE**
Hematological: Anemia/ Leukemia/ Cholesterol/ Other ___________ **NONE**
Gastrointestinal: Crohns/ Colitis/ Other ____________ **NONE**

Have you experienced any of these eye symptoms in the last month?
Fluctuating vision [ ] contact lens discomfort[ ] light sensitivity[ ] watery eyes[ ] Tired eyes[ ] redness [ ]
Burning [ ] Itching [ ] Feeling of sand or grit in eye [ ]

Family History (Blood Relatives): Yes / No / (Who)

Cancer: ____________________________ Dry Eye: _________________________
Diabetes: ____________________________ Glaucoma: _________________________
Heart Disease: ____________________________ Macular Degeneration: _________________________
Stroke/HTN: ____________________________ Cataracts: _________________________
Arthritis: ____________________________ Eye Injury / Surgery: _________________________

Notes/ Other Ailments: ____

Reviewed by Dr____ Date ___________________