South East Eye Family Vision Center *a Vision Source member practice*

Dr. Miri Park, Optometrist Patient History Form (Confidential by Law)

☺ *WELCOME TO OUR OFFICE* ☺

Please take a few minutes to provide us with the following information.

Last Name________________________ First Name________________________

Street________________________ City________________________

Zip__________ Date of Birth_____/_____/_____ Last 4 of SSN__________

Home#________________________ Work#________________________

Cell#________________________ Occupation________________________

Email________________________

How did you hear about our office?________________________

Health Insurance________________________

ID#________________________ Employer________________________

Subscriber Name________________________

DOB_____/_____/_____ Relationship to subscriber □ SELF □ SPOUSE □ CHILD □ OTHER

Do you have a Vision Plan? Yes □ No □ Plan Name & ID#

____

PRIMARY REASON FOR TODAY'S EXAM (Please check all that apply)

□ Routine Eye Exam □ Contact Lens Exam □ Other________________________

Last Eye Exam_____/_____/_____ Where________________________

□ Wear Glasses □ for distance □ for reading □ progressives □ bi-focals

□ Wear Contacts □ every day □ sometimes □ mono vision □ bi-focal contacts

□ daily disposable □ 2 wk disposable □ monthly disposable □ Interested in Lasik

Hours per Day__________ Years Worn__________

Care System/Solutions________________________

□ Previously Wore Contacts for how long?__________ year stopped?__________

why did you stop?________________________

Annual eye health checks are an important part of your health care program. Can we reserve your next appointment? □ **YES**

We will send you a reminder 1 month in advance of your appointment; if that day and time is inconvenient we will be happy to reschedule it for you.

PERSONAL MEDICAL INFORMATION

Last physical exam? ______/______/______ Name of Primary Care Physician and town

____

Do you have any allergic reactions to medications or other substances? ☐ **Yes** ☐ **No**

If yes, please list____

Please list any medications you are taking

____

Do you experience or have you had any of the following?

☐ Blurred Vision	☐ Loss of Vision	☐ Flashes of light	☐ Floating Spots
☐ Dryness	☐ Redness	☐ Burning	☐ Itchy/Scratchy
☐ Eye Injuries	☐ Eye Infections	☐ Eye strain/fatigue	

If you are having any other eye problems at this time, please explain

____

Have you or your blood relatives had any of the following conditions?

	Yourself	Family		Yourself	Family
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	☐ Yes ☐ No
Eye Surgery	☐ Yes ☐ No	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	☐ Yes ☐ No
Retinal Tear/Detachment	☐ Yes ☐ No	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No	☐ Yes ☐ No
Lazy Eyes	☐ Yes ☐ No	☐ Yes ☐ No	Respiratory (asthma)	☐ Yes ☐ No	☐ Yes ☐ No
Patching/Vision Therapy	☐ Yes ☐ No	☐ Yes ☐ No	Skin disorders	☐ Yes ☐ No	☐ Yes ☐ No
Color Blindness	☐ Yes ☐ No	☐ Yes ☐ No	Headaches/Numbness	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	Gastrointestinal (gastritis,celiac,IBS)	☐ Yes ☐ No	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	☐ Yes ☐ No	Allergic/Immunologic (allergies,immune disorders	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	Depression/Anxiety	☐ Yes ☐ No	☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Other condition(s)______________________________________

Smoke? ☐ Yes ☐ No How many/day?______________ Alcohol? ☐ Yes ☐ No How often?____________

Special visual demands (work or hobbies)

____