DAYTON OPTOMETRIC CENTER PATIENT HISTORY FORM

Patient Name_____**Date of Birth**_____

Visual History

Briefly describe the main reason for having an examination today:

_____

Do you have any symptoms related to this?

_____

Please list all eyedrops you use (prescription or over-the-counter)_____

_____

Do you wear?: ☐ Glasses ☐ Contacts ☐ Reading glasses ☐ None

Do you have prescription sunglasses? ☐ Yes ☐ No

Are you troubled by glare? ☐ Yes ☐ No

If you currently wear or have worn contact lenses, what brand are they? _____

What contact lens solutions do you use?_____

How often do you replace your contacts? _____

Are you interested in a contact lens exam today (extra fee)? ☐ Yes ☐ No

Do you have a history of any of the following:

☐Blindness	☐Glaucoma
☐Eye Turn (Strabismus)	☐Cataracts
☐Lazy Eye (Amblyopia)	☐Macular Degeneration
☐Keratoconus	☐Retinal Detachment

Are you currently experiencing any of the following?

☐Headaches	☐Eyes itch	☐Eyes feel dry
☐Blurred Vision	☐Eyes burn	☐Eyes water
☐Double Vision	☐Eyes red	☐Flashing lights
☐Halos around lights	☐Eyes tired	☐Floaters

Other eye problems, eye conditions or eye diseases:

_____

_____

Have you had any eye injuries? ☐ Yes ☐ No If yes, describe:_____

Have you had any eye surgeries? ☐ Yes ☐ No If yes, please list_____

How many hours a day do you use a computer or electronic device (including phones and games)?

☐ Less than 2 hours ☐ 2-4 hours ☐4-6 hours ☐6-8 hours ☐ more than 8 ☐ None

Describe any visual symptoms from computer use:_____

Medical History

Primary Care Physician's Name:_____ Phone:_____

Address:_____

Preferred Pharmacy_____

Address_____

List all medications you are taking (including over-the-counter and vitamins) or provide a list.

_____

_____

_____

_____ ☐ I take no medications or vitamins

Do you have any allergies to medications? ☐ Yes ☐ No If Yes, please list:_____

Height:_____ Weight:_____ Are you pregnant or nursing? ☐ Yes ☐ No

Please review and check any conditions in the following body systems. If no, please check "None"

Constitutional/General
☐None
☐Developmental Delay
☐Weight Loss
☐Fever
☐Fatigue

Ear, Nose, Mouth, Throat
☐None
☐Upper Respiratory Infection
☐Sinus

Cardiovascular/Heart
☐None
☐High Blood Pressure
☐Vascular Disease
☐Heart Disease
☐Stroke

Respiratory/Breathing
☐None
☐Asthma
☐Emphysema
☐Bronchitis
☐COPD

Endocrine
☐None
☐Thyroid Dysfunction
☐Diabetes ☐Type 1 ☐ Type 2 ☐ Gestational Diabetes ☐ Prediabetic/borderline

Stomach/Digestion
☐None
☐Reflux
☐Crohn's Disease
☐Colitis
☐Ulcer

Genitourinary
☐None
☐Urinary Tract Infection
☐Kidney Ailments
☐Prostate
☐STD

Muscles/Bones
☐None
☐Arthritis
☐Muscular Dystrophy
☐Fibromyalgia

Blood/Liver
☐None
☐Anemia
☐High Cholesterol
☐Leukemia
☐Hepatitis

Skin
☐None
☐Eczema
☐Rosacea
☐Psoriasis
☐Growths

Neurological
☐None
☐Headaches
☐Multiple Sclerosis
☐Epilepsy
☐Alzheimers/Dementia

Psychiatric
☐None
☐Depression
☐Panic Disorder
☐Schizophrenia
☐Bipolar Disorder

Allergy/Immunologic
☐None
☐Lupus
☐HIV/AIDS
☐Allergies
type_____

If Diabetic, what year were you diagnosed? _____

Is your blood sugar controlled/stable? ☐ Yes ☐ No

What was your last blood sugar reading? _____What was your last HbA1C reading? _____

For other conditions not listed above, please list on the following page

Other Medical Conditions:

_____

_____

_____

Social History

Occupation: _____

Hobbies:_____

How often do you smoke/use tobacco products?

☐Never ☐Daily (less than 10 cigarettes/day) ☐Daily (more than 10 cigarettes/day)

☐Occasionally (not daily) ☐Former Smoker

How often do you consume alcohol? ☐Never ☐Occasionally ☐Daily

Race: ☐White ☐Black or African America ☐Asian ☐American Indian or Alaska Native

☐Pacific Islander ☐Prefer not to answer

Ethnicity: Are you Hispanic/Latino? ☐Yes ☐No ☐Prefer not to answer

Preferred language:_____

Family History

Is there any history of the following in any family members? (parents, grandparents, siblings, children)

Condition	Relationship to Patient				
☐Y ☐N Blindness	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Eye Turn (Strabismus)	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Lazy Eye (Amblyopia)	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Glaucoma	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Cataracts	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Macular Degeneration	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Retinal Detachment/Disease	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Cancer	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Diabetes	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N High Blood Pressure	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Stroke	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Thyroid Disease	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Other Inherited Disease	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child

If yes, what disease?_____

☐ Family history is unknown/adopted