Academy Contact Lens Clinic

Patient Health Information:

Date: ____/____/____

Last Name____________________________ First Name_________________________ M.I.________
What name do you wish to be called?_____________________D.O.B.____/____/____ Male / Female
Address:_________________________________ City_________________ State______ Zip______
Home Ph:(   )________________Work Ph:(   )________________Cell Ph:(   ) _______________
E-Mail Address:__________________________________ Best Contact: HOME WORK CELL
Employer/ School________________________________ Occupation/ Grade ____________________
Emergency Contact:_____________________ Relation:________________ Phone # ______________

History/ Reason for Visit:

Date of Last Medical Exam:______/______/______ Clinic/ Physician:___________________________
Date of Last Eye Exam (if other than here):______/______/______ Clinic: ___________________________
Do you wear glasses? YES NO ALWAYS WORK ONLY READING ONLY DRIVING ONLY
Do you wear contacts? YES NO ALWAYS WEEKENDS SPORTS OTHER _________________
If yes, what type? ____
Are you interested in wearing contact lenses? YES NO UNDECIDED
Are you interested in Lasik surgery? YES NO UNDECIDED
Have you had eye injuries/ surgeries? YES NO EXPLAIN:___________________________________
Have you used eye medication? YES NO EXPLAIN: ___________________________________
Have you been diagnosed with? CATARACTS GLAUCOMA MACULAR DEGENERATION DIABETES
Do you work on a computer? YES NO HOW MANY HRS/ DAY?_________________________
Females: Are you pregnant or nursing? YES NO

Visual Symptoms: Circle any that apply:

Blurred Vision/ Distance	Burning Eyes	Floaters/ Spots	Headaches
Blurred Vision/ Near	Itchy Eyes	Flashes of Light	Migraines
Double Vision	Dry Eyes	Halos	Loss of Vision
Eye Strain	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infection	Watery Eyes	Poor Color Vision	Light Sensitivity
Eye Pain/ Soreness	Wandering Eye	Droopy Lid	Sandy/ Gritty Feeling
Tired Eyes	Mucus Discharge	Other:____	

Form Review:

Date/ Initial______________________ Date/ Initial______________________
Date/ Initial______________________ Date/ Initial______________________
Date/ Initial______________________ Date/ Initial______________________
Date/ Initial______________________ Date/ Initial______________________

CONFIDENTIAL

**PLEASE TURN OVER AND COMPLETE OTHER SIDE*

Personal Medical History: Please check if any of the following applies to you.

Cardiovascular: None_____	**Endocrine:** None_____	**Respiratory:** None_____
____ Hypertension(high blood pressure) ____Stroke ____Heart Disease ____High Cholesterol ____ Other:	____ Non-Insulin Dep. Diabetes ____ Insulin Dep. Diabetes ____ Thyroid Problem ____ Hormonal Dysfunction ____ Other:	____ Asthma ____ Bronchitis ____Emphysema ____ COPD ____ Other:
Constitutional: None_____ ____ Cancer (type)________________ ____ Trauma/Lg. Blood Loss ____ Developmental Disability ____ Other:	**Ocular:** None_____ ____ Glaucoma ____Macular Degeneration ____ Detached Retina ____ Other:	**Psychiatric:** None_____ ____ ADHD ____ Depression ____ Schizophrenia ____ Other:
Neurological: None_____ ____ Multiple Sclerosis ____ Epilepsy ____ Cerebral Palsy ____ Tumor ____ Other:	**Musculoskeletal:** None_____ ____ Osteoarthritis ____Fibromyalgia ____Muscular Dystrophy ____ Other:	**Immunological:** None_____ ____ AIDS or HIV ____ Rheumatoid Arthritis ____ Lupus ____ Neurofibromatosis ____Other:
Hematological: None_____ ____ Anemia ____ Leukemia ____ Other:	**Gastrointestinal:** None_____ ____ Crohn's ____ Colitis ____ Other:	**Ear/ Nose/ Throat:** None_____ ____ Hearing Loss ____ Upper Resp. Infection ____ Other:
Dermatologic: None_____ ____ Eczema ____ Rosacea ____ Psoriasis ____Other:	**Allergies** (please list): None_____ Drug: Environmental:	**Alcohol Use:** Yes No Amount:____________ **Tobacco Use:** Yes No Amount:____________

Please list physical reactions to above allergies:____

Please list any medications/ drugs/ vitamins that you are taking and for what condition:

1.______________________ for__________________ 5.______________________for__________________

2.______________________for __________________ 6.______________________for__________________

3.______________________for__________________ 7.______________________for__________________

4.______________________for __________________ 8.______________________for__________________

Family History: Has anyone in your family (grandparents, parents, siblings, children) been diagnosed with:

Disease/ Condition:

Retinal Detachment:	Yes/ No	Who:_________________	Blindness:	Yes/ No	Who:_________________
High Blood Pressure:	Yes/ No	Who:_________________	Cataracts:	Yes/ No	Who:_________________
Diabetes:	Yes/ No	Who:_________________	Glaucoma:	Yes/ No	Who:_________________
Thyroid Disease:	Yes/ No	Who:_________________	Crossed Eyes:	Yes/ No	Who:_________________
Heart Disease:	Yes/ No	Who:_________________	Lupus:	Yes/ No	Who:_________________
Macular Degeneration:	Yes/ No	Who:_________________	Cancer:	Yes/ No	Who:_________________

Reviewed By:

Patient Signature:__________________________________ Date:___________________________

Doctor Signature:__________________________________ Date:___________________________