

NORTHWEST EYECARE PROFESSIONALS HEALTH AND VISION HISTORY FORM

Date of last vision exam _____ Full Name of Doctor _____
 Date of last physical exam _____ Full Name of Doctor _____

Does any **blood relative** have any of the following conditions? (please circle)

Diabetes	Arthritis	Cataract	Eye Tumors
Lupus	Cancer	Glaucoma	Eye(s) Turn
Thyroid	Hypertension	Macular Degeneration	Amblyopia (lazy eye)
Migraine headaches	Heart Disease	Retinal Detachment	Other _____

Are you currently receiving treatment from a physician? Yes No If yes: _____
 Have you recently had any illness? Yes No If yes: _____
 Are you presently taking or using any medication? Yes No If yes: _____
 (Women) Are you pregnant or nursing? Yes No
 Do you use any of the following products?
 Tobacco? Yes No Alcohol? Yes No Recreational drugs? Yes No

Eyewear
 Do you currently wear glasses? Yes No
 If yes, how often? All the Time For reading only For computer only For distance vision only
 Indicate which lens features you may be interested in for your *new glasses*:
 Thin and lite lenses anti-reflective lenses computer glasses rolled and polished edges
 no-line bifocals prescription sunglasses ultraviolet block lenses that change color
 Do you currently wear contact Lenses? Yes No If no, are you interested in trying contact lenses? Yes No
 How often do you replace your contact lenses? _____ How long are you able to wear your contact lens? _____
 What brand of lenses are you wearing? _____ Current Cleaning Solution? _____
 Do you sleep in your contacts lenses? Yes No Rarely
 How many hours per day do you spend on a computer? _____
 Do you have headaches/eyestrain during or after computer work? Yes No

Do **you** have a problem with any of the following? (Please circle Yes or No and use the box to provide additional information, if necessary.)

Constitution			Cardiovascular			Musculoskeletal					
Other	Yes	No	Congestive Heart Failure	Yes	No	Arthritis	Yes	No			
Cancer	Yes	No	Heart Disease	Yes	No	Ankylosing Spondylitis	Yes	No			
Developmental Disabilities	Yes	No	Stroke/CVA	Yes	No	Fibromyalgia	Yes	No			
Fatigue Syndrome	Yes	No	Hypertension	Yes	No	Gout	Yes	No			
ENT			Other	Yes	No	Osteoporosis	Yes	No			
Laryngitis	Yes	No	Psych			Muscular Dystrophy	Yes	No			
Hearing Loss	Yes	No	Depression	Yes	No	Osteoarthritis	Yes	No			
Dry Mouth	Yes	No	Anxiety Disorder	Yes	No	Other	Yes	No			
Sinusitis	Yes	No	Bipolar Disorder	Yes	No	Integumentary					
Other	Yes	No	Attention Deficit	Yes	No	Cold Sores	Yes	No			
Neuro			Other	Yes	No	Eczema	Yes	No			
Epilepsy	Yes	No	Gastrointestinal			Psoriasis	Yes	No			
Tumor	Yes	No	Celiac Disease	Yes	No	Rosacea	Yes	No			
Cerebral Palsy	Yes	No	Ulcer	Yes	No	Shingles	Yes	No			
Migraine	Yes	No	Colitis	Yes	No	Other	Yes	No			
Multiple Sclerosis	Yes	No	Acid Reflux	Yes	No	Endocrine					
Stroke/CVA	Yes	No	Chrohn's Disease	Yes	No	Diabetes Mellitus I	Yes	No			
Other	Yes	No	Other	Yes	No	Diabetes Mellitus II	Yes	No			
Respiratory			Genitourinary			Hormonal Dysfunction	Yes	No			
Asthma	Yes	No	Pregnant	Yes	No	Thyroid Dysfunction	Yes	No			
Emphysema	Yes	No	Nursing	Yes	No	Other	Yes	No			
Cigarette Smoker	Yes	No	Kidney Disease	Yes	No	Hematologic/Lymphatic					
Chronic Obstruction	Yes	No	Prostate Disease/Cancer	Yes	No	Anemia	Yes	No			
Bronchitis	Yes	No	Benign Prostate Hypertrophy	Yes	No	Large-Volume Blood Loss	Yes	No			
Sleep Apnea	Yes	No	STD	Yes	No	Hypercholesterolemia	Yes	No			
Other	Yes	No	Other	Yes	No	Ulcer	Yes	No			
Other/Additional Information: 						Other	Yes	No			
						Alleg/Immunologic					
						Sjogren's Syndrome	Yes	No			
						Rheumatoid Arthritis	Yes	No			
						Lupus	Yes	No			
						Drug Allergies	Yes	No			
Environmental Allergies	Yes	No									
Other	Yes	No									