NORTHWEST EYECARE PROFESSIONALS
HEALTH AND VISION HISTORY FORM

Patient's Full Name ________________________________

Date of last vision exam_____________ Full Name of Doctor____
Date of last physical exam__________ Full Name of Primary Care Physician (PCP)_______________________
PCP Practice Name or Location ________________________________

Does any **blood relative** (living or deceased) 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: ______________________
(Women) Are you pregnant or nursing? ❑ Yes ❑ No
Are you presently taking or using any medication? ❑ Yes ❑ No
If yes:

____
____
____
____

Do you use any of the following products?
- Alcohol? ❑ Yes ❑ No
- Tobacco? ❑ Yes ❑ No
- Former Smoker? ❑ Yes ❑ No
- Recreational drugs? ❑ Yes ❑ No

Please indicate your race (optional):
❑ White ❑ Black / African American ❑ Asian
❑ American Indian ❑ Hispanic / Latino ❑ Other

Preferred Language? ________________________

Eyewear Assessment

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
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

If no, are you interested in trying contact lenses? ❑ Yes ❑ No

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 or are being treated for 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	**Respiratory**			Muscular Dystrophy	Yes	No
Hearing Loss	Yes	No	Asthma	Yes	No	Osteoarthritis	Yes	No
Dry Mouth	Yes	No	Emphysema	Yes	No	Other	Yes	No
Sinusitis	Yes	No	Smoker	Yes	No	**Integumentary**		
Other	Yes	No	Chronic Obstruction	Yes	No	Cold Sores	Yes	No
Neuro			Bronchitis	Yes	No	Eczema	Yes	No
Epilepsy	Yes	No	Sleep Apnea	Yes	No	Psoriasis	Yes	No
Tumor	Yes	No	Other	Yes	No	Rosacea	Yes	No
Cerebral Palsy	Yes	No	**Gastrointestinal**			Shingles	Yes	No
Migraine	Yes	No	Celiac Disease	Yes	No	Other	Yes	No
Multiple Sclerosis	Yes	No	Ulcer	Yes	No	**Endocrine**		
Stroke/CVA	Yes	No	Colitis	Yes	No	Diabetes Type 1	Yes	No
Other	Yes	No	Acid Reflux	Yes	No	Diabetes Type II	Yes	No
Psych			Crohn's Disease	Yes	No	Hormonal Dysfunction	Yes	No
Depression	Yes	No	Other	Yes	No	Thyroid Dysfunction	Yes	No
Anxiety Disorder	Yes	No	**Genitourinary**			Other	Yes	No
Bipolar Disorder	Yes	No	Pregnant	Yes	No	**Hematologic/Lymphatic**		
Attention Deficit	Yes	No	Nursing	Yes	No	Anemia	Yes	No
Other	Yes	No	Kidney Disease	Yes	No	Large-Volume Blood Loss	Yes	No
Other/Additional Information:			Prostate Disease/Cancer	Yes	No	High Cholesterol	Yes	No
			Benign Prostate Hypertrophy	Yes	No	Ulcer	Yes	No
			STD	Yes	No	Other	Yes	No
			Other	Yes	No	**Allergy/Immunologic**		
						Sjogren's Syndrome	Yes	No
						Rheumatoid Arthritis	Yes	No
						Lupus	Yes	No
						Drug Allergies	Yes	No
						Environmental Allergies	Yes	No

If you are a new patient, whom may we thank for referring you to us?		
❑ Insurance Plan	❑ Current Patient: ______________________	
❑ Primary Care Physician	❑ Yellow Pages	❑ Other Website: ________________________