Vision Patient Health History Form

PRAIRIE STAR Health Center

LAST NAME	FIRST	DATE OF BIRTH	AGE
ADDRESS		DATE OF LAST VISION EXAM	
ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? ☐ YES ☐ NO		IF YES, FOR WHAT?	
NAME OF PRIMARY CARE PROVIDER		**PREFERRED PHARMACY**	
SPECIALIST(S) YOU ARE CURRENTLY SEEING			

GENERAL HEALTH

IS YOUR GENERAL HEALTH GOOD?	☐ YES	☐ NO
HAS THERE BEEN A CHANGE IN YOUR OVERALL HEALTH WITHIN THE LAST YEAR?	☐ YES	☐ NO
HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE LAST 3 YEARS?	☐ YES	☐ NO
IF YES, PLEASE EXPLAIN		DATE OF HOSPITALIZATION
HAVE YOU BEEN DIAGNOSED WITH AN OCULAR DISEASE?	☐ YES	☐ NO
HAVE YOU HAD ANY EYE SURGERIES OR EYE TRAUMAS?	☐ YES	☐ NO
DO YOU WEAR GLASSES?	☐ YES	☐ NO
DO YOU WEAR CONTACT LENSES?	☐ YES	☐ NO

PAST AND PRESENT MEDICAL PROBLEMS (PLEASE CHECK)

CARDIOVASCULAR	EYES, EARS, NOSE & MOUTH	ENDOCRINE
☐ HIGH BLOOD PRESSURE	☐ EYE DISEASE	☐ THYROID DISEASE: ☐ HYPO ☐ HYPER
☐ HEART ATTACK	☐ SINUS PROBLEMS	☐ DIABETES: ☐ Type 1 ☐ Type 2
☐ HEART DISEASE	**GASTROINTESTINAL**	☐ DRY MOUTH
☐ PACEMAKER	☐ STOMACH PROBLEMS	**RHEUMATOLOGY**
GENERAL	☐ ULCERS	☐ ARTHRITIS / RHEUMATISM
☐ FEVER	☐ HEPATITIS: ☐ A ☐ B ☐ C	**HEMATOLOGY**
☐ WEIGHT GAIN	**INFECTIOUS DISEASE**	☐ BLEEDING PROBLEMS
☐ WEIGHT LOSS	☐ AIDS / HIV	☐ EASY BRUISING
URINARY	☐ HERPES	☐ BLOOD TRANSFUSION
☐ KIDNEY DISEASE	**PSYCHOLOGICAL**	☐ ANEMIA
☐ BLADDER DISEASE	☐ ANXIETY	**ONCOLOGY**
PULMONARY	☐ DEPRESSION	☐ CANCER
☐ ASTHMA	**NEUROLOGICAL**	☐ TUMORS
☐ COPD / EMPHYSEMA	☐ DIZZINESS	☐ CHEMOTHERAPY
☐ TUBERCULOSIS	☐ SEIZURES / EPILEPSY	☐ RADIATION TREATMENTS
WOMEN ONLY	☐ HEADACHE	**ALLERGIES**
☐ PREGNANT OR NURSING	☐ MIGRAINE	☐ FOOD
☐ TAKING BIRTH CONTROL PILLS	☐ STROKE/HARDENING OF ARTERIES	☐ MEDICATIONS
		☐ LATEX

FAMILY HISTORY OF:

☐ DIABETES	☐ GLAUCOMA	☐ MACULAR DEGENERATION

SOCIAL HISTORY

☐ RECREATIONAL DRUGS	☐ TOBACCO (IN ANY FORM)	☐ ALCOHOL

(Continue on Reverse)

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MEDICATION HISTORY

OCULAR MEDICATIONS:
OTHER MEDICATIONS (INCLUDING OVER THE COUNTER):
MEDICATION ALLERGIES:

SURGERIES

Please list any surgeries you have had.

VISION HISTORY & SURGERIES
MEDICAL HISTORY & SURGERIES

PATIENT/GUARDIAN SIGNATURE	DATE
PSHC PROVIDER SIGNATURE	DATE