Perfect Pair Optometry

Patient Health History Form

Patient Name: _____ Date of Birth: _____ Age: _____

Parent's Name (If patient is a minor): _____

Gender: ☐ Male ☐ Female Is this your first visit to our office: ☐ Yes ☐ No

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Occupation: _____

Cell Phone: _____ Alternate Phone: _____

Who may we thank for referring you to our office? _____

What are the reasons for your visit? _____

_____

Family Health History			
☐ Blindness	☐ Cancer	☐ Cataracts	☐ Diabetes
☐ Glaucoma	☐ High blood pressure	☐ Lazy eye (amblyopia)	☐ Macular degeneration
☐ Poor color vision	☐ Stroke	☐ Thyroid condition	☐ Turned eye
Patient's Health History			
☐ Allergies	☐ Asthma	☐ Blindness	☐ Cancer
☐ Cataracts	☐ Diabetes	☐ Glaucoma	☐ Heart condition
☐ High blood pressure	☐ High cholesterol	☐ HIV/AIDS	☐ Lazy eye (amblyopia)
☐ Migraine headaches	☐ Poor color vision	☐ Skin conditions	☐ Stroke
☐ Thyroid conditions	☐ Tuberculosis		
Patient's Health History			
☐ Distance vision blur	☐ Near vision blur	☐ Burning eyes	☐ Double vision
☐ Dry eyes	☐ Eye infection	☐ Eye injury	☐ Eye strain
☐ Headaches	☐ Itching eyes	☐ Light sensitivity	☐ Red eyes
☐ See flashing lights	☐ See floaters	☐ Temporary loss of vision	
☐ Turned eye	☐ Twitching eyelids	☐ Watery eyes/tearing	

Explanation of health history, if necessary: _____

_____

Are you pregnant or nursing? ☐ Yes ☐ No

Are you currently taking any medications or drugs? ☐ Yes ☐ No

If yes, what are you taking? _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, which? _____

Have you had any serious eye disease, eye injury, or eye surgery? ☐ Yes ☐ No

If yes, please explain: _____

When was your last eye examination? _____ Who was your previous eye doctor? _____

When was your last visit to your physician? _____ Who is your physician? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, which type? ☐ Soft ☐ Hard

Which brand of contact lenses do you wear? _____

Signature: _____ Date: _____