Vision Source - South Valley
Health Information

Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. (Please Print)

Name____ Today's Date___________________
First MI Last

Is this exam the result of an injury?_________________ accident?____________ automobile accident?_____________

Date of last eye exam _______________________ Name of eye doctor ______________________________________
Do you currently wear glasses? ☐ Yes ☐ No How old is your present pair of glasses? ___________________
When do you wear your glasses?
☐ All the time ☐ Reading/near work ☐ Distance tasks only
☐ Work/safety ☐ Computer work ☐ Other, please explain ________________
Have you ever worn contact lenses? ☐ Yes ☐ No Wear now? ☐ Yes ☐ No
Are they comfortable? ☐ Yes ☐ No Date last replaced?__________________________
Are you interested in wearing contact lenses? ☐ Yes ☐ No
If so, what style?
☐ Soft ☐ Extended Wear ☐ Gas Permeable ☐ Bifocal
☐ Tinted ☐ Astigmatic ☐ Disposable ☐ Unsure
Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes
If yes, please describe: ____

Medical Doctor: Name____________________________________ Telephone________________________________
Date of last exam _________________________ Address___________________________________
____

How is your general health? ____
Please list any allergies____
List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):
____
____
List all major injuries, surgeries and/or hospitalizations you have had: ____
____

Some health conditions (such as diabetes and glaucoma), recent eye injuries, being very near-sighted, or being over age 50, place you at greater risk for eye health problems inside your eye and you should have your pupils dilated. Dilating the pupil allows us to more thoroughly examine the inside of your eye. This may make your vision more blurry, especially at near, and will make you more sensitive to light for a few hours.
☐ I DO ☐ I DO NOT give permission for my eyes to be dilated. **Please initial here ________**

Exactly how we choose to correct your vision is related to the type of work you do and/or the hobbies you are involved in. Please check all that apply to you.
☐ Computer work ☐ Construction work ☐ Use power tools ☐ Sewing/crafts
☐ Prolonged close work ☐ Use hazardous chemicals ☐ Racquetball/Tennis ☐ Hunting/Fishing
☐ Drive a lot ☐ In the sun a lot ☐ Swimming/Diving ☐ Skiing/Snow sports
☐ Lots of dirt/dust ☐ Other sports ____
☐ Need safety glasses ☐ Other activities ____

Family History
Please mark all boxes that apply to your family history (parents, grandparents, siblings, children: living or deceased). Please write their relationship to you on the appropriate line.
☐ Blindness _____________________________________ ☐ Cancer____________________________________
☐ Cataract ______________________________________ ☐ Diabetes __________________________________
☐ Crossed Eyes __________________________________ ☐ Heart Disease ______________________________
☐ Glaucoma _____________________________________ ☐ High Blood Pressure ________________________
☐ Macular Degeneration ___________________________ ☐ Kidney Disease ____________________________
☐ Retinal Detachment/Disease ______________________ ☐ Arthritis __________________________________
☐ Color vision problems ___________________________ ☐ Thyroid Disease ____________________________
☐ Other eye problems _____________________________ ☐ Other illnesses _____________________________

Social History (Check here ☐ if you prefer to discuss social history with your doctor.)

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long:_____________________________
Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long:___________________________________
Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long:_________________________________
Have you ever been exposed to or infected with: ☐ None ☐ Gonorrhea? ☐ Syphilis? ☐ Hepatitis? ☐ HIV?

Review of Systems

Do you currently, or have you had in the last ten years, any problems in the following areas:

ALLERGY ☐ None
☐ Animal Dander ☐ Cigarette Smoke ☐ Dust ☐ Foods - (list) ____________________
☐ Molds/Mildew ☐ Penicillin ☐ Pollens ☐ Sulfa Drugs
☐ Others - (list) ____

CARDIOVASCULAR ☐ None
☐ Angina ☐ Arrythmia ☐ Elevated Cholesterol ☐ Heart Attack
☐ Heart Disease ☐ Heart Murmur ☐ Hypertension ☐ Stoke

CONSTITUTIONAL ☐ None
☐ Blackouts/Fainting ☐ Dizziness ☐ Fever ☐ Weight Loss/ Gain

ENDOCRINE ☐ None
☐ Diabetes ☐ Gout ☐ Hypoglycemia ☐ Pituitary Disorder
☐ Renal Disease ☐ Thyroid Disorder

EYES
☐ Blindness ☐ Blurred Vision ☐ Distorted Vision ☐ Loss of Side Vision
☐ Double Vision ☐ Dryness ☐ Burning ☐ Sandy or Gritty Feeling
☐ Redness ☐ Itching ☐ Mucous Discharge ☐ Foreign Body Sensation
☐ Tired Eyes ☐ Eye Pain/Soreness ☐ Flashing Lights ☐ Excess Tearing/Watering
☐ Floaters in Vision ☐ Glare/Light Sensitivity ☐ Other _______________

GASTROINTESTINAL ☐ None
☐ Acid Reflux ☐ Anorexia ☐ Gall Stones ☐ Cancer (☐ Colon or ☐ Liver)
☐ Ulcer ☐ Diarrhea (other than occasional) ☐ Constipation (other than occasional)

GENITOURINARY ☐ None
☐ Bladder ☐ Menopause ☐ Ovarian Cyst/Tumor Cancer (☐ Prostate or ☐ Uterine)

HEAD ☐ None
☐ Chronic Cough ☐ Dental Disorder ☐ Ear Infection ☐ Headaches
☐ Hearing Loss ☐ Sinusitis

HEMATOLOGIC/LYMPHATIC ☐ None
☐ Anemia ☐ Hodjkin's Disease ☐ Leukemia ☐ Sickle Cell Disease

IMMUNOLOGIC ☐ None
☐ AIDS/HIV Positive ☐ Herpes Simplex ☐ Herpes Zoster ☐ Histoplasmosis
☐ Rheumatic Fever ☐ Sarcoidosis ☐ Sjogren's Syndrome

INTEGUMENTARY (Skin) ☐ None
☐ Acne ☐ Acne Rosacea ☐ Eczema ☐ Lupus
☐ Psoriasis ☐ Warts ☐ Other _______________

MUSCULOSKELETAL ☐ None
☐ Arthritis ☐ Rheumatoid Arthritis ☐ Marfan's Syndrome ☐ Muscular Dystrophy
☐ Myasthenia Gravis ☐ Scoliosis

NEUROLOGICAL ☐ None
☐ Bell's Palsy ☐ Brain Injury ☐ Brain Tumor ☐ Cerebral Palsy
☐ Dyslexia ☐ Epilepsy ☐ Multiple Sclerosis ☐ Parkinson's Disease
☐ Seizure Disorder ☐ Spinal Cord Injury

PSYCHIATRIC ☐ None
☐ Attention Disorder ☐ Anxiety Disorder ☐ Autism ☐ Bipolar Disorder
☐ Depression ☐ Learning Disability ☐ Mentally Challenged ☐ Schizophrenia

RESPIRATORY ☐ None
☐ Asthma ☐ COPD ☐ Cystic Fibrosis ☐ Emphysema
☐ Lung Cancer ☐ Lung Disease ☐ Tuberculosis

Reviewed by _______________