Dr. Ralph Williams
Dr. Leah McConnaughey
Dr. Khristopher Ballard

Patient Name:_____Date of Birth:_____Date:_____

History Form

What brings you in today_____

Eye history: With vision correction being used do you suffer from any of the following(please circle answer)

Distance Vision Blur	Yes	No	*Seeing flashes*	Yes	No	*Dry eyes*	Yes	No	*Itching*	Yes	No
Near Vision Blur	Yes	No	*Distorted vision*	Yes	No	*Red eyes*	Yes	No	*Discharge*	Yes	No
Mid distance blur	Yes	No	*Crossed eyes*	Yes	No	*Eye pain*	Yes	No	*Burning*	Yes	No
Double vision	Yes	No	*Headaches*	Yes	No	*Glare*	Yes	No			

Have you been diagnosed or treated for any of the following?

Glaucoma Yes No *Cataracts* Yes No *Age related macular degeneration* Yes No
Diabetic eye disease Yes No *Retinal disease* Yes No *Blindness* Yes No *Eye turn(strabismus)* Yes No
Lazy eye(amblyopia) Yes No *Eye injury* Yes No *Dry eye* Yes No

Have you had eye surgery?

Type of sugery:_____Eye:_____Surgeon:_____Date:_____

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What eye drops are you using?How often?_____

Vision history: Please circle the corresponding answer or fill in the blanks

Glasses worn:

Do not wear

Distance/driving only

Near/Reading only

Full time

Age of current glasses:_____

Examination history:

*Referred by:*_____

*Last eye exam:*_____

*Location of last eye exam:*_____

Contact lens history(only answer below if you wear contact lenses)

Type or brand of contact lenses worn:_____

How often do you replace your lenses:_____

What brand of contact lens solution do you soak your lenses in overnight:_____

How often do you sleep in your lenses(please circle): Never Rarely 1-2x/wk 3 or more nights/wk 30days at a time

What is your typical wear schedule?_____hours/day_____Days/week_____

Review of Systems: Many diseases of the body can significantly affect the eyes. Please answer the following questions. While they may seem unrelated to an eye problem it is important for your care that we ask them.

Do you currently have any of the following problems?(If yes please explain)

Yes No Diabetes_____Onset_____ Type_____

If diabetic please answer the following questions

How often do you check your blood sugar at home: Never 1x/wk 2-3x/wk Daily 2 or more times daily

What does your blood sugar usually run_____What was your last hemoglobin A1c_____%

Yes No Chronic fever, unexpected weight loss/gain, fatigue_____

Yes No Heart problems(high blood pressure, chest pain, irregular heart beat etc.)_____

Yes No Ear/nose/throat problems(hearing loss, sinus problems, sore throat) _____

Yes No Respiratory problems(shortness of breath, wheezing, coughing) _____

Yes No Gastrointestinal problems(heartburn, diarrhea, vomiting, abdominal pain) _____

Yes No Genitourinary problems(painful urination, blood in urine, sex organ problems) _____

Yes No Musculoskeletal problems(muscle aches, joint pain, swollen joints) _____

Yes No Skin problems(rashes, excessive dryness, growths, lumps)_____

Yes No Neurological problems(numbness, weakness, headaches)_____

Yes No Psychiatric problems(depression, anxiety)_____

Yes No Endocrine problems(thyroid, pituitary, parathyroid problems)_____

Yes No Blood/Lymph problems(bruising, weakness, lymphoma,) _____

Yes No Immune problems(frequent infections)_____

Yes No Autoimmune disorders(Lupus, Rheumatoid arthritis, Sjogrens syndrome)_____

Yes No Other_____

Family history: Please specify if any of your blood relatives have any medical or eye diseases(please specify relation)

Glaucoma_____Cataracts_____Macular degeneration_____

Diabetes_____Retinal disease_____Blindness_____

Eye turn(strabismus)_____Lazy eye(amblyopia)_____Cancer_____

Heart disease_____High blood pressure_____High cholesterol_____

Kidney disease_____Stroke_____Color blindness_____

Neurological disease(multiple sclerosis)_____Thyroid problems _____

Medications-please list both prescription and over the counter medications

Medication Allergies(please list)_____

Do you smoke? Never Some days Every day Former smoker _____# packs/day

Do you drink alcohol? Never Daily Rarely _____#drinks/week