

WELCOME TO ST. PAUL EYE CLINIC, P.A.

Please complete both sides of the following health history for your records

1. **Name** _____ **Date** _____ **Your age** _____

I would like to be addressed as _____

2. Name of person(s) authorized to request information regarding my medical care and treatment:

3. Some insurance plans pay for preventive eye care. If you do have a vision benefit through your insurance plan, do you wish to use that benefit for this visit?

No Yes

4. What questions or concerns would you like addressed at today's visit?

5. Do you wear glasses? No Yes

How old is the prescription? _____

6. Do you wear contact lenses? No Yes

What type/brand name? _____

How many hours per day? _____

How old are the lenses? _____

7. If "no" would you be interested in contacts? No Yes

8. Do you have any of the following eye symptoms?

Blurred vision No Yes

Eye Pain No Yes

Red eyes No Yes

Discharge No Yes

Flashes No Yes

Floaters No Yes

Double vision No Yes

Sensitivity to light No Yes

9. Do you take any medications?

If "yes," please list them _____

10. Are you allergic to any medications? No Yes

If "yes," please list them _____

11. Do you have a latex sensitivity? No Yes

12. Does anyone in your immediate family (parent, child, sibling) have any of the following?

Glaucoma No Yes **Who** _____

Cataract No Yes **Who** _____

Retinal detachment No Yes **Who** _____

Diabetes No Yes **Who** _____

Genetic disorders No Yes **Who** _____

Macular Degeneration No Yes **Who** _____

13. Have you ever had any of the following eye problems?
- | | | |
|------------------------|-----------------------------|------------------------------|
| Injury to the eye | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Any disease of the eye | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Laser treatment | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Eye Surgery | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
- If "yes" to any, please describe _____

14. Have you ever had any of the following ear, nose, or throat problems?
- | | | |
|----------------|-----------------------------|------------------------------|
| Hay Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Sinus problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
- Other _____
15. Do you have, or have you had high blood pressure? No Yes
16. Do you have or have you had diabetes? No Yes
17. Do you have asthma or emphysema? No Yes
18. Have you ever had kidney stones or kidney problems? No Yes
19. Have you ever had any of the following heart problems?
- | | | |
|--------------------------|-----------------------------|------------------------------|
| Heart attack | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Congestive heart failure | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Chest pains | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Heart murmur | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Heart surgery | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
- Other _____
20. Have you ever had any of the following neurological problems?
- | | | |
|--------------------|-----------------------------|------------------------------|
| Stroke | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Migraine Headaches | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Multiple sclerosis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
- Other _____
21. Do you have any infectious disease? No Yes
22. Do you smoke? No Yes
If "yes", for how long? _____
23. Do you have a history of sleep apnea? No Yes
24. Please list below any other comments, questions, or information that you would like us to know.
- _____
- _____
- _____
- _____
- _____

THANK YOU