The information in this confidential personal history form is critical to the evaluation of your vision

Patient History Name_____ Date_____

Address_____ City_____ ZIP_____

Home Phone (_____)_____ Cell Phone (_____)_____

Work Phone(_____)_____ Ext. _____

Date of your last eye examination_____ Have you ever had vision therapy? ❑ Yes ❑ No

Have you ever worn glasses? ❑Yes ❑No Do you wear glasses now? ❑ Yes ❑No

If yes: ❑ for distance only ❑ for near only ❑ wear them full time ❑ for computer monitor ❑ sports

This is your opportunity to tell us about all areas in which your vision is not serving you well.

What is your main reason for coming here today? _____

_____

Are there times when your vision (or present lens) isn't quite right? _____

_____

Are there any activities you would enjoy doing, but must restrict because of your vision? _____

_____

HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.

Allergies	❑Self	❑ Family	Lazy eye	❑ Self	❑ Family
Respiratory disease	❑Self	❑ Family	Turned eye	❑ Self	❑ Family
Cancer	❑Self	❑ Family	Color "blind"	❑ Self	❑ Family
Diabetes	❑Self	❑ Family	Light sensitive	❑ Self	❑ Family
Drug sensitive	❑Self	❑ Family	Eyestrain	❑ Self	❑ Family
Elevated cholesterol	❑Self	❑ Family	Dry eyes	❑ Self	❑ Family
Heart problem	❑Self	❑ Family	Floaters/spots	❑ Self	❑ Family
High blood pressure	❑Self	❑ Family	Flashing lights	❑ Self	❑ Family
Thyroid	❑Self	❑ Family	Retinal detachment	❑ Self	❑ Family
Migraine or headaches	❑Self	❑ Family	Blindness	❑ Self	❑ Family
Head trauma	❑Self		Cataracts	❑ Self	❑ Family
			Glaucoma	❑ Self	❑ Family
			Eye surgery or injury	_____	

Are you currently under a physician's care? ❑No ❑ Yes Dr.'s name? _____

Are you regularly taking medications? ❑No ❑ Yes Date of last physical _____

For what conditions? 1_____ 2_____ 3_____ 4_____

How is your general health? (circle one) Excllelent Good Fair Poor

VERY IMPORTANT! ***NEW PATIENTS:*** *WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?*

*Name of friend or relative*_____

If not referred, how did you choose our office for your visual needs? Please check the appropriate answer:

❑ Relative ❑ Another Dr. Yellow Pages: ❑ Milpitas ❑ San Jose ❑ Hayward/Fremont

❑ Friend ❑ Insurance List ❑ Saw Sign/Building ❑Other_____

Please fill in both sides of this form as completely as possible

Do you wear contact lenses at this time? ❑Yes ❑No What type? _____

OCCUPATION: What kind of work do you do?_____

What activities do you do at work: ***(Circle all that apply)*** driving typing data entry computers program inspecting accounting writing/editing using spread-sheets loading deliveries sales monitor instruments.

Other activities: _____

Do you use a computer on your job?	**❑ Yes**	**❑ No**	# hours daily _____	
Do you use a computer at home?	**❑ Yes**	**❑ No**	# hours daily _____	
What lenses do you wear?	**❑ None**	**❑ glasses**	**❑ bifocals**	**❑ contacts**
When computing, do your eyes get	**❑ red**	**❑ dry**	**❑ ache**	**❑ Sore**
Do you feel pain or discomfort in your. . .	**❑ neck**	**❑ back**	**❑ shoulder**	
Do letters ever seem to "swim"?	**❑ Yes**	**❑ No**		
Does office lighting bother you?	**❑ Yes**	**❑ No**		
Do reflections and glare bother you? . . .	**❑ Yes**	**❑ No**		
Is it hard to proof-read, or find errors?. . .	**❑ Yes**	**❑ No**		

Do you experience any of the following discomforts at work or at home?

❑ Headaches? ❑ Letters blur as you read? ❑ Occasionally see double?
❑ Eyestrain? ❑ Eyes red or watery? ❑ Pulling sensation near eyes?
❑ Get sleepy? ❑ Lose your place often? ❑ Do you avoid certain tasks?
❑ Does it take more and more effort to see clearly as the day wears on?
❑ Do you avoid reading after work, but read on weekends? How long can you read?_____
❑ Do you "hunch" closer to your work as the day wears on?
❑ Do street signs ever seem blurred as you drive home from work?
❑ Is it ever difficult to bring print or objects to clear focus? When_____

RECREATION AND LEISURE:

In what recreational activities do you participate? (*Circle* all that apply) read racquetball tennis golf baseball basketball swim camp sew play cards flying video games musical instrument

Other recreational activities_____

Do you wear any special or protective eyewear for your sport? **❑ Yes ❑ No**

Does your vision, or do your lenses, interfere with any activity? **❑ Yes ❑ No**

Television: is viewing ever uncomfortable? Please describe your discomfort:_____

_____

Do you recline while viewing? **❑ Yes ❑ No** **D**o your lenses work for TV? **❑Yes ❑ No**

Do you often play video games? ❑ Yes ❑ No # of hours daily_____

Midtown Vision Development Center
Better Learning Through Better Vision