

Community Eye Care of Indiana, Inc.  
Patient Health History

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Family physician: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Your email address: \_\_\_\_\_

Would you like emails regarding updates and optical shop specials? YES\_\_ NO\_\_

Do you have a vision plan? YES\_\_ NO\_\_ If yes, please circle below...  
VSP, EYEMED, DAVIS VISION, SPECTERA, COLE, other \_\_\_\_\_

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Are you currently experiencing any of these symptoms? (Please circle all that apply)

Blurred or poor vision	Dry eyes	Watery eyes
Trouble reading	Dry mouth/skin	Gritty eyes
Trouble watching TV	Eye pain/irritation	Light sensitivity
Trouble on computers	Floaters	Trouble driving at night
Glare/Halos around lights	Headaches	Matting/crusting of eyelids

Do you currently wear contacts? YES\_\_\_ NO\_\_\_ If NO, are you interested? \_\_\_\_\_

If you currently wear contacts, please answer the following...

What brand? \_\_\_\_\_

What Power? \_\_\_\_\_

How often do you replace your contacts? \_\_\_\_\_

What contact lens solution do you use?

Opti Free, AMO, Renu, Aquify, Boston, or generic

CONTINUED ON THE BACK

**Do you smoke?** YES \_\_\_ NO \_\_\_ If YES, how much? \_\_\_\_\_

**Do you drink alcohol?** YES \_\_\_ NO \_\_\_ If YES, how much? \_\_\_\_\_

**Do any medical or eye diseases run in your family?** YES \_\_\_ NO \_\_\_

If YES, please list and note relationship to patient: \_\_\_\_\_

**Do you have any drug allergies?** YES \_\_\_ NO \_\_\_

If YES, please explain: \_\_\_\_\_

**List all medications** (if too many- please provide a list) If none, check here \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Are you pregnant or nursing?** YES \_\_\_ NO \_\_\_

Do you currently have any of the following problems? Please check Yes or No. If YES, please explain.

1. <b>Eyes</b> (injuries/surgeries, retinal problems, glaucoma, cataract, lazy eye, specify any other)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. <b>Ear/nose/mouth/throat</b> (hearing loss, sinus, problems, sore throat)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. <b>Cardiovascular</b> (CHF, heart problems/attack, chest pain, high blood pressure, irregular heart beat)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. <b>Respiratory</b> (COPD, asthma, shortness of breath, wheezing, coughing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. <b>Gastrointestinal</b> (GERD, heartburn, abdominal, pain, diarrhea, vomiting, stomach stapling, colon surgery)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. <b>Musculoskeletal</b> (arthritis, muscle aches, joint pain, swollen joints)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. <b>Neurological</b> (MS, numbness, weakness, stroke, headache, paralysis, seizure, alzheimer's, parkinson's)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. <b>Hematologic/Lymphatic</b> (blood disorders, leukemia, cancer, hepatitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. <b>Endocrine</b> (diabetes, thyroid problems, lupus) If diabetes, when were you diagnosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. <b>Psychiatric</b> (depression, anxiety)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. <b>Integumentary</b> (skin problems, skin cancer)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. <b>Genito/Urinary</b> (prostate cancer, ovarian cancer)	<input type="checkbox"/> Yes <input type="checkbox"/> No	