

Welcome to **OPTICS PLUS**
MEDICAL HISTORY INFORMATION

NAME _____ DATE OF BIRTH _____ EXAM DATE _____
(LAST) (FIRST) (M.I.)

Do you currently wear glasses? YES / NO If YES, what are they for? _____

Do you currently wear contact lenses? YES / NO If YES, what type? _____

Do you have problems with any of the following?

DOUBLE VISION	HEADACHES	REDNESS OF EYES	EXCESSIVE TEARING
DRY EYE	CROSSED EYES	EYE PAIN	ITCHING / BURNING EYES
FLOATERS	FLASHES OF LIGHT	LIGHT SENSITIVITY	

Have you had any of the following contidions?

EYE INFECTION?	Y / N	If YES, When?	_____
EYE INJURY	Y / N	If YES, When?	_____
EYE SURGERY	Y / N	If YES, When?	_____
LASIK SURGERY	Y / N	If YES, When?	_____

Please list ANY medication that you are currently taking.

ARE YOU ALLERGIC TO ANY MEDICATIONS?

Other Allergies?

Are you currently being treated for any of the following?

Diabetes	Thyroid Problems	High Blood Pressure	Asthma	Lung Disease
High Cholesterol	Seasonal Allergies	Pregnancy	Glaucoma	Cataracts
Retinal Detachment		Macular Degeneration		

Among your BLOOD relatives, has there been a history of the following?

Macular Degeneration	_____	Heart Attack	_____
Diabetes	_____	Stroke	_____
Glaucoma	_____	Cancer	_____
Retinal Detachment	_____	Other	_____

Do any of the following situations cause visual discomfort or stress?

Low Lights	Driving	Computer Monitors
Bright Lights	Night Driving	Cell Phones / PDA Devices
Reading	TV / Movies / Shows	Sports / Hobbies

Do you participate in any of the activities or hobbies which may be affected by you vision?

Computer Use	Reading	Bicycling	Sewing
Snow Sports	Woodworking / Crafts	Boating / Water Sports	Hunting / Shooting
Home Repairs	Gardening	TV / Movies / Shows	Travel
Cards / Games	Golf / Tennis		

Your privacy is important to us. ALL PATIENT INFORMATION IS STRICTLY CONFIDENTIAL and is collected to be used exclusively for effective vision care. Please contact our office manager to review our statement of HIPPA Compliance (also available on our website: www.optics-plus.com)