Welcome To *Enhance* Eye Care **Patient History Form**

Patient Name: ____ Date: ____

Current medications and eye drops (including over-the-counter): **None** (circle if you are not taking any medications)

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Please list any allergies: **None** (circle if you do not have any allergies)

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What is the reason for your visit?

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Check if you experience any of the following (with your current prescription), if applicable:

_____ Blurry vision when reading _____ Glare at night

_____ Red, burning eyes toward end of the day _____ Blurry vision at computer

_____ Discomfort in bright sunlight _____ Blurry vision at distance

_____ Itchy, watery eyes _____Other ____

For CL wearers: how many days are you wearing new pair of CLs before your eyes feel dry? ________________________

Please list any activity that you feel may have additional visual requirement(s)

(Ex: computer-8 hr/day, reading-5 hr/day, pilot, golfer, knit, etc.)

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Check if any of the following conditions apply to you or your family:

Self	Family		Self	Family		Self		Self	
___	___	Glaucoma	___	___	Macular Degeneration	___	Pregnant	___	Eye Injury
___	___	Eye Surgery	___	___	Cancer ____________	___	Smoker	___	CL wearer, past
___	___	Retinal Disease				___	Drink Alcohol	___	CL wearer, now
___	___	Eye Turn (in/out)				___	Flashes of lights in vision		
___	___	Double Vision				___	Floaters in vision		
___	___	Cataract							

Check if any applies to you:

			If yes, please explain
Cardiovascular: Heart problems (high blood pressure, chest pain, irregular heart beat…)	___Y	___N	__________________________
Constitutional: Chronic Fever, unexpected weight loss/gain, fatigue…	___Y	___N	__________________________
Endocrine: Cholesterol, Diabetes, Thyroid…	___Y	___N	__________________________
Gastrointestinal: heartburn, stomach pain, diarrhea, vomiting…	___Y	___N	__________________________
Genitourinary: pain or discomfort, blood in urine…	___Y	___N	__________________________
Ear/nose/throat problems (hearing loss, sinus problems, sore throat)…	___Y	___N	__________________________
Hematologic/Lymphatic: bruising/bleeding easily, anemia, sickle cell…	___Y	___N	__________________________
Immunologic: HIV positive, Bacterial/Viral Infections…	___Y	___N	__________________________
Integumentary: skin rashes, excessive dryness…	___Y	___N	__________________________
Musculoskeletal: muscle aches, joint pain, swollen joints…	___Y	___N	__________________________
Neurological: numbness, weakness, headaches, paralysis…	___Y	___N	__________________________
Psychiatric: depression, anxiety…	___Y	___N	__________________________
Respiratory: shortness of breath, wheezing, coughing…	___Y	___N	__________________________