SPECIALTY Eyecare Group
A MEMBER OF VISION SOURCE™

HEALTH Information Form

Pt Name_____ **D.O.B.** _____

Last Eye Exam On: _____ Doctor's Name: _____ Phone# _____

Medical Doctor: _____ Clinic: _____ Phone# _____

Other Doctor: _____ Clinic: _____ Phone# _____

Medications (Prescribed and OTC) _____

Allergies (Medications):_____

Allergies (Seasonal/Other):_____

Developmental Delays? _____

Therapy/Tutoring? _____ Provider: _____

Therapy/Tutoring? _____ Provider: _____

Personal Eye Health History								
	Y	**N**		**Y**	**N**		**Y**	**N**
Full time glasses wear			White appearance in pupil			Frequent loss of place		
Glasses wear for distance only			Squinting/eye rubbing/blinking			Omits/Inserts/re-reads' letters or words		
Glasses wear for near only			Headaches			Poor reading comprehension		
Soft contact lens wear			Red/Itchy eyes			Confuses similar looking words		
Rigid contact lens wear			Blurry/double vision			Reversals after 1st grade		
Strabismus surgery			Crossed or Lazy eye			Smart in everything but school		
*If yes, Right eye			Head tilting/closing eye			Fatigue/frustration with homework		
*If yes, Left eye			Difficulty copying from board			Fatigue/frustration with reading		
Previous eye injuries			Poor handwriting, misaligns numbers			Difficulties with reading		
*If yes, Right eye			Inconsistent/poor sports performance			Difficulties with spelling		
*If yes, Left eye			Holds books closely			Difficulties with math		
Any loss of vision			Avoidance of near work			Is your child meeting their potentials		

Previous head trauma/injury? If yes, when? _____What Occurred?: _____

Sports/Hobbies/Activities: _____

What activities require protective eyewear? _____

SOCIAL HISTORY

Drinking: **YES/NO** Amount (Weekly): _____ Recreational Drug Use: **YES/NO** Type/Amount_____

Smoking Status: **YES/NO** Amount (Weekly): _____ Current/Former/Heavy/Light/Never

Personal Health History								
Constitutional	**Y**	**N**	**Cardiovascular/Respiratory**	**Y**	**N**	**Musculo/Integ/Endocrine**	**Y**	**N**
Developmental Disabilities			Hypertension			Arthritis: Osteo/ Rheumatoid		
Cancer			Stroke/CVA			Fibromyalgia		
Fatigue Syndrome			Heart Disease			Muscular Dystrophy		
Other?			Vascular Disease			Ankylosing Spondylitis		
ENT			Congestive Heart Failure			Osteoporosis		
Hearing Loss			Other			Gout		
Sinusitis			Cigarette Smoker			Eczema		
Dry Mouth			Asthma			Rosacea		
Laryngitis			Bronchitis/ Emphysema			Psoriasis		
Other			Chronic Obstruction			Herpes Simplex (cold sores)		
Neurological			Sleep Apnea			Herpes Zoster (shingles)		
Multiple Sclerosis			Other			Type 1 Diabetes Mellitus		
Epilepsy			**Gastrointestinal/Genitourinary**			Type 2 Diabetes Mellitus		
Cerebral Palsy			Crohn's Disease			Thyroid Dysfunction		
Tumor			Colitis			Hormonal Dysfunction		
Stroke			Ulcer			Other		
Migraine			Acid Reflux			**Hemotological/Lymphatic/Immune**		
Other			Celiac Disease			Anemia		
Psychological			Kidney Disease			Large-volume Blood Loss		
Depression			Prostate Disease/Cancer			Ulcer		
Attention Deficit			STD			Hypercholesteremia		
Anxiety Disorder			Benign Prostate Hypertrophy			Lupus		
Bipolar Disorder			Pregnant/ Nursing			Sjogren's Syndrome		
Other			Other			Other		

Family Medical and Ocular History										
Condition	**Y**	**N**	**Mother**	**Father**	**Sister**	**Brother**	**Mat. G-mother**	**Mat. G-father**	**Pat. G-mother**	**Pat. G-father**
Cancer:										
Diabetes Mellitus										
Diabetes Mellitus Type 1										
Diabetes Mellitus Type 2										
Hypertension										
Hyperthyroidism										
Hypothyroidism										
Thyroid Disorder										
Cataract										
Macular Degeneration										
Glaucoma										
Other:										