LEGACY OPTICAL

PATIENT HISTORY FORM

DEMOGRAPHICS:

Name: _____ **DOB:** _____ **Age:** _____

Address: _____ **Phone:** _____

_____ **Email:** _____

Birth Sex: ❑ Male ❑ Female Preferred Gender:_____

Preferred Pronouns: ❑ He/Him ❑ She/Her ❑ Other:_____

Ethnicity: ❑ American Indian or Alaska Native ❑ Asian
❑ Black or African American ❑ Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander ❑ White

Relationship Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Employment Status: ❑ Employed ❑ Unemployed ❑ Retired
❑ Student ❑ Active Military

Occupation: _____ **Hobbies:** _____

OCULAR HISTORY:

When was your last eye exam? _____ **Do you wear glasses?** ❑ Yes ❑ No

History of eye surgery?: ❑ No ❑ Yes **Do you wear contact lenses?** ❑ Yes ❑ No

Type of eye surgery:_____

Purpose of today's visit (please check all that apply):

❑ Blurry Vision ❑ Headaches ❑ Eye pain
❑ Double vision ❑ Focusing issues ❑ Visual issues after Concussion/TBI
❑ Burning ❑ Itchiness ❑ Redness
❑ Tearing/Watering ❑ Dryness ❑ Foreign body sensation
❑ Difficulty with night vision/glare ❑ Flashes of light in vision
❑ Floaters/spots in vision ❑ Loss of vision/blackout of vision
❑ Other: _____

Have you ever been diagnosed with or previously had any of the following eye conditions?

❑ Corneal abrasion ❑ Dry Eye ❑ Iritis/Uveitis
❑ Eye infection ❑ Eye injury ❑ Blindness
❑ Lazy Eye/Amblyopia ❑ Eye Turn/Strabismus ❑ Cataracts
❑ Glaucoma ❑ Macular Degeneration ❑ Retinal Hole/Tear/Detachment
❑ Other eye diseases: _____ ❑ None of the above

Has anyone in your family ever been diagnosed with any of the following eye conditions?

❑ Blindness ❑ Eye Turn/Strabismus ❑ Lazy Eye/Amblyopia
❑ Cataracts ❑ Glaucoma ❑ Macular Degeneration
❑ Retinal Detachment ❑ Dry Eye ❑ Other: _____
❑ None of the above

TURN OVER

MEDICAL HISTORY:

Primary Care Physician: _____ **Last PCP Visit:** _____

Do you have any specialists?: ❑ No ❑ Yes: _____

_____

Have you ever been diagnosed or treated for any of the following health problems?

(please check all that apply): ❑ None

❑ Allergies	❑ Arthritis	❑ Asthma	❑ Autoimmune disease
❑ Blood/Lymph	❑ Cancer	❑ Cholesterol	❑ Concussion (TBI)
❑ COPD	❑ Diabetes	❑ Digestive/G.I.	❑ Ears/Nose/Throat
❑ Endocrine	❑ GERD/acid reflux	❑ Heart Disease/CHF	❑ High blood pressure
❑ Integument (skin)	❑ Kidney disease	❑ Muscle/Bone	❑ Neurological
❑ Psychological	❑ Reproductive/STD	❑ Respiratory	❑ Seizures
❑ Sinus	❑ Stroke	❑ Thyroid disease	❑ Vertigo/dizziness

Are you currently pregnant or nursing? ❑ N/A ❑ No ❑ Yes

Do you drink alcohol? ❑ No ❑ Yes

How often?: _____

Do you smoke? (tobacco, vape/e-cigarettes): ❑ Never ❑ Current smoker ❑ Former smoker

How often? _____ How long were you/have you been a smoker? _____

How long ago did you quit smoking? _____

Do you use recreational drugs? ❑ No ❑ Yes

Please list all medications and over the counter supplements you currently take: ❑ None

_____

_____

_____

_____

_____

_____

Medication allergies: ❑ None

_____

_____

Please list any prior surgeries and approximate dates: _____

_____

_____

Has anyone in your family ever been diagnosed with any of the following conditions?

❑ Cancer	❑ Diabetes	❑ Heart disease
❑ High blood pressure	❑ Neurological disorders	❑ Thyroid disease
❑ None of the above		