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| **Rosin Eyecare Health History** |
| First Name: \_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_­­\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Identity: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Are you interested in LASIK? [ ]  Yes [ ]  NoPrimary Care Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Physician Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Physician Hospital Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you currently have any of the following? C*heck all that apply* |
| [ ]  Blurred Distance Vision[ ]  Blurred Near Vision[ ]  Trouble with Current Eyewear[ ]  Tired Eyes/Eye Strain[ ]  Poor Night Vision/Difficulty with Glare | [ ]  Floaters or Spots[ ]  Flashes of light[ ]  Regular Headaches☐ Double Vision☐ Pregnant / Nursing | [ ]  Dryness[ ]  Sandy or gritty Feeling[ ]  Watery Eyes[ ]  Redness[ ]  Itchy Eyes |
| Do you currently or have you ever had any of the following? C*heck all that apply* |
| [ ]  Amblyopia (“Lazy Eye”)[ ]  Cataract[ ]  Glaucoma[ ]  Macular Degeneration[ ]  Retinal Detachment[ ]  Eye Surgery[ ]  Other Eye Disorders: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Heart Disease[ ]  Hypertension[ ]  High Cholesterol[ ]  Cancer (Please Specify Type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Anemia[ ]  Leukemia | [ ]  Loss of Appetite[ ]  Dizziness[ ]  Diabetes Mellitus: [ ]  Type 1 [ ]  Type 2[ ]  Thyroid Disease[ ]  Other Endocrine Disorders[ ]  Gastrointestinal Disorders[ ]  Sexually Transmitted Disease[ ]  Headaches[ ]  Migraine[ ]  Sinusitis[ ]  HIV / AIDS[ ]  Herpes Zoster (Shingles) | [ ]  Acne Rosacea[ ]  Eczema[ ]  Lupus[ ]  Multiple Sclerosis[ ]  Psychiatric Disorders[ ]  Asthma[ ]  Emphysema[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medications & Allergies** |
| Are you allergic to any medications? [ ]  No [ ]  Yes If yes, to what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have any non-medication allergies? [ ]  No [ ]  Yes If yes, to what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please List all medications (including over the counter medicines, vitamins/supplements, and eye drops) you are taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Family History (*Please check all that apply and specify relation*)** |
| [ ]  Amblyopia (“Lazy Eye”) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Eye Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Glaucoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Keratoconus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Macular Degeneration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Retinal Detachment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Blindness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Other Eye Disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ High Cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Social History** |
| Do you use any cigarettes or tobacco? [ ]  Never [ ]  Former Smoker [ ]  Current Smoker [ ]  How many packs per day?\_\_\_\_\_\_Do you drink alcohol? [ ]  No [ ]  Social Drinker [ ]  1 to 2 Drinks Daily [ ]  More than 2 drinks dailyDo you use other substances? [ ]  Yes [ ]  No  |

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| **Eyewear History** |
| **Glasses** |
| What kind of glasses do you currently own? *Check all that apply*[ ]  Distance[ ]  Near[ ]  Computer[ ]  Multifocal[ ]  Backup Pair(s) | [ ]  Safety Glasses[ ]  Sunglasses[ ]  Sports Glasses[ ]  Transitions[ ]  OtherHow many hours per day are you on a computer? \_\_\_\_\_\_\_\_ |
| **Contacts** |
| What type of contact lenses do you wear?[ ]  Soft Daily [ ]  Soft Bi Weekly [ ]  Soft Monthly [ ]  Hard / Gas Permeable [ ]  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What brand of contacts do you wear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Referral** |
| How were you referred to us?[ ]  Drive/Walk by[ ]  Website[ ]  Insurance Company[ ]  Other |

Reviewed: Initials\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_ Initials\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_ Initials\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_ Initials\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_