JJ Optical Patient History

Today's Date:_____

Name:_____ Title: _____ Birth Date:_____

Street Address:_____ Social Security #:_____

City, State, Zip Code:_____ Student: ☐ yes ☐ no

Home Phone:_____ Married: ☐ yes ☐ no

Cell Phone:_____ Occupation:_____

Employer:_____

Full Time ☐ Part time ☐

Medical Insurance:_____ Responsible Party:_____

Vision Insurance:_____ DOB/SSN:_____

Primary Care Provider:_____

PCP Phone #:_____ Previous Eye Doctor:_____

Last Medical Exam:_____ Last Eye Exam:_____

Medical History:

Do you have any allergies to medications? ☐ yes ☐ no

If yes, explain:_____

List any medications you take (including oral contraceptives, aspirin, OTC medications and home remedies):

_____

_____

List all major injuries, surgeries, and/or hospitalizations:_____

_____

Are you pregnant and/or nursing? ☐ yes ☐ no ☐ n/a

Do you wear glasses? ☐ yes ☐ no If yes, how old are your current lenses? _____

Do you wear contact lenses? ☐ yes ☐ no If yes, how old are your current lenses? _____

Type of contact lenses:_____ Are they comfortable? ☐ yes ☐ no

Please note if a **family member** (parents, grandparents, siblings, children) have any of the following:

Disease/Condition	**Yes**	**No**	**Relationship to You**
Blindness	☐	☐	
Cataract	☐	☐	
Crossed Eyes	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Retinal Detachment/Disease	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Kidney Disease	☐	☐	
Lupus	☐	☐	
Thyroid Disease	☐	☐	

(Turn over to complete)

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.* Yes, I'd like to discuss this directly with my doctor. (Check box.)

Do you drive? ☐ yes ☐ no If yes, do you have any visual difficulty when driving? ☐ yes ☐ no
If yes, describe:

Do you use tobacco products? ☐ yes ☐ no If yes, type/amount/how long:_____
Do you drink alcohol? ☐ yes ☐ no If yes, type/amount/how long:_____
Do you use illegal drugs? ☐ yes ☐ no If yes, type/amount/how long:_____

Review of Systems

Do you currently, or have you ever had any problems in the following areas?

System	Yes	No	Unsure	System	Yes	No	Unsure
Constitutional				Ears, Nose, Mouth, Throat			
Fever/Weight Loss/Gain	☐	☐	☐	*Allergies/Hay Fever*	☐	☐	☐
Integumentary				*Sinus Congestion*	☐	☐	☐
Skin	☐	☐	☐	*Runny Nose*	☐	☐	☐
Neurological				*Post-Nasal Drip*	☐	☐	☐
Headaches	☐	☐	☐	*Chronic Cough*	☐	☐	☐
Migraines	☐	☐	☐	*Dry Throat/Mouth*	☐	☐	☐
Seizures	☐	☐	☐	Respiratory			
Eyes				*Asthma*	☐	☐	☐
Loss of Vision	☐	☐	☐	*Chronic Bronchitis*	☐	☐	☐
Blurred Vision	☐	☐	☐	*Emphysema*	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐	Vascular/Cardiovascular			
Loss of Side Vision	☐	☐	☐	*Diabetes*	☐	☐	☐
Double Vision	☐	☐	☐	*Heart Pain*	☐	☐	☐
Dryness	☐	☐	☐	*High Blood Pressure*	☐	☐	☐
Mucous Discharge	☐	☐	☐	*Vascular Disease*	☐	☐	☐
Redness	☐	☐	☐	Gastrointestinal			
Sandy or Gritty Feeling	☐	☐	☐	*Diarrhea*	☐	☐	☐
Itching	☐	☐	☐	*Constipation*	☐	☐	☐
Burning	☐	☐	☐	Genitourinary			
Foreign Body Sensation	☐	☐	☐	*Genitals/Kidney/Bladder*	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐	Bones/Joints/Muscles			
Glare/Light Sensitivity	☐	☐	☐	*Rheumatoid Arthritis*	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐	*Muscle Pain*	☐	☐	☐
Chronic Infection of Eye/Lid	☐	☐	☐	*Joint Pain*	☐	☐	☐
Sties or Chalazion	☐	☐	☐	Lymphatic/Hematologic			
Flashes/Floaters in Vision	☐	☐	☐	*Anemia*	☐	☐	☐
Tired Eyes	☐	☐	☐	*Bleeding Problems*	☐	☐	☐
Drooping Eyelids	☐	☐	☐	Allergic/Immune	☐	☐	☐
Endocrine				Psychiatric	☐	☐	☐
Thyroid/Other Glands	☐	☐	☐				

If you answered yes to any of the above or have a condition not listed, please explain:_____