MAREN SMITHGALL-BROWN, OD
OPTOMETRIC PHYSICIAN

Today's Date: _____

PATIENT INFORMATION

Patient Name: _____ Birthdate: _____ Age: _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

Occupation: _____ Student Grade (*if applicable*): _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred method of contact: Cell Home Work Email

Phone: Cell _____ Home _____ Work _____

Email: _____

Who may we thank for referring you to our practice? _____

Name of person responsible for this account if other than patient: _____

EYE HEALTH HISTORY

Date of last exam: _____Reason for today's exam: _____

Do you wear eyeglasses? □Yes □No *If Yes:* □Full Time □Occasionally □Reading □Driving/TV

Do you wear contact lenses? □Yes □No *If No:* Are you interested in trying contacts? □Yes □No

- How often do you discard your contacts? □Daily □Biweekly □ Monthly □Quarterly □Yearly
- Do you take your contacts out at night? □Yes □No □Sometimes
- What disinfection system/cleaning solution do you use? _____
- Please describe any problems you are having with your contacts: _____

  _____

Please mark Yes or No if you have experienced any of the following:

Bloodshot Eyes	□ Yes	□ No	Glaucoma	□ Yes	□ No
Blurred Vision-Distance	□ Yes	□ No	High Eye Pressure	□ Yes	□ No
Blurred Vision-Near	□ Yes	□ No	Itchy Eyes	□ Yes	□ No
Cataracts	□ Yes	□ No	Lazy Eye	□ Yes	□ No
Discharge from Eyes	□ Yes	□ No	Light Flashes	□ Yes	□ No
Double Vision	□ Yes	□ No	Light Sensitivity	□ Yes	□ No
Dry/Sandy Eyes	□ Yes	□ No	Poor Night Vision	□ Yes	□ No
Eye Injury or Surgery	□ Yes	□ No	Seeing Halos	□ Yes	□ No
Eyestrain	□ Yes	□ No	Vision Therapy	□ Yes	□ No
Frequent Headaches	□ Yes	□ No	Watery Eyes	□ Yes	□ No
			Other: _____		

HEALTH HISTORY

Please mark Yes or No if you have had any of the following. Please mark Yes or No for **family history** as well.

	Self		Family			Self		Family	
AIDS/HIV	□ Yes	□ No	□ Yes	□ No	Hypertension	□ Yes	□ No	□ Yes	□ No
Arthritis	□ Yes	□ No	□ Yes	□ No	Kidney Disease	□ Yes	□ No	□ Yes	□ No
Asthma	□ Yes	□ No	□ Yes	□ No	Macular Degeneration	□ Yes	□ No	□ Yes	□ No
Autoimmune Disorder	□ Yes	□ No	□ Yes	□ No	Retinal Disease	□ Yes	□ No	□ Yes	□ No
Cancer	□ Yes	□ No	□ Yes	□ No	Stroke	□ Yes	□ No	□ Yes	□ No
Diabetes	□ Yes	□ No	□ Yes	□ No	Thyroid Condition	□ Yes	□ No	□ Yes	□ No
Glaucoma	□ Yes	□ No	□ Yes	□ No	Tuberculosis	□ Yes	□ No	□ Yes	□ No
Heart Condition/Disease	□ Yes	□ No	□ Yes	□ No	Alcohol Use	□ Yes	□ No	□ Yes	□ No
Hepatitis	□ Yes	□ No	□ Yes	□ No	Tobacco Use	□ Yes	□ No	□ Yes	□ No

Please list any medications you are currently taking (Including eye drops or over the counter medication):

_____

_____

_____

Please list any allergies to medication: _____

_____

LIFESTYLE HISTORY

Approximately how many hours do you spend on the computer daily? _____

Approximately how much time do you spend outdoors for either work or recreation? _____

Do you perform fine or up-close work? □Yes □No *If Yes*, please specify what type: _____

What sports or recreational activities do you enjoy?

□ Aerobics/Fitness Walking
□ Baseball/Softball
□ Basketball
□ Cycling
□ Fishing
□ Football
□ Golf
□ Handball
□ Martial Arts
□ Motorcycle
□ Racquet Sports
□ Rollerblading/Skateboarding
□ Shooting Sports
□ Skiing/Snow Sports
□ Soccer
□ Swimming
□ Water Sports/Sailing/Jet Ski
□ Other: _____