Eye Associates of Green Bay, SC

Patient Health Form

Patient Name: _____

Date of Birth:_____ Height: _____ ft. _____ in. _____ Weight: _____ lbs.

Health History

What is the main reason for today's exam? ☐ Medical ☐ Wellness

When was your last exam?	When was your last health exam?

List any major surgeries including the year the surgery occurred:

Medications

List medications and dosages:

Current eye drops:

Allergies

Please list any allergies and reactions:

Patient Current Eye Symptoms

☐ Glare Sensitivity	☐ Eyelid Swelling	☐ Redness	☐ Floaters/Spots
☐ Headaches	☐ Eye Pain/Soreness	☐ Sandy or Gritty Feeling	☐ Fluctuating Vision
☐ Light Sensitivity	☐ Foreign Body Sensation	☐ Blurred Vision Distance	☐ Loss of Central Vision
☐ Tired Eyes	☐ Infection of Eyelid	☐ Blurred Vision Near	☐ Loss of Side Vision
☐ Burning	☐ Itching	☐ Distorted Vision (Halos)	☐ Loss of Vision
☐ Dryness	☐ Mucous Discharge	☐ Double Vision	☐ Other _____
☐ Excessive Watering	☐ Ptosis (Drooping Eyelid)	☐ Flashes of Light	☐ Other

NEW PATIENT ONLY - Eye Diseases

☐ Amblyopia (Lazy Eye)	☐ Color Blindness	☐ Glaucoma	☐ Vitreous Detachment
☐ Inflammation of Eyelid	☐ Diabetic Retinopathy	☐ Glaucoma Suspect	☐ Retinal Detachment
☐ Blindness	☐ Dry Eye Syndrome	☐ High Risk Medication	☐ Strabismus (Eye Turn)
☐ Cataract	☐ Eye Injuries	☐ Macular Degeneration	☐ Other

Patient Medical History

☐ Fever	☐ Emphysema/COPD	☐ Rash/Itching	☐ Diabetes
☐ Fatigue	☐ Shortness of Breath	☐ Rosacea	☐ Thyroid Disease
☐ Hearing Loss	☐ Intestinal Conditions	☐ Shingles	☐ Anemia
☐ Sinus Disorders	☐ Flomax Use	☐ Skin Cancer	☐ High Cholesterol
☐ Atrial Fibrillation	☐ Kidney Disease	☐ Multiple Sclerosis	☐ Seasonal Allergies
☐ Heart Disease	☐ Urinary Conditions/Symptoms	☐ Frequent Headaches	☐ Lupus
☐ High Blood Pressure	☐ Arthritis	☐ Convulsion/Seizure	☐ Other _____
☐ Stroke/TIA	☐ Muscle/Joint/Back Pain	☐ Memory Loss	☐ Pregnant (currently)
☐ Asthma	☐ Herpes	☐ Depression	☐ Nursing (currently)

Family Medical History (Biological)

(Check all that apply and indicate family member)

Eye Diseases		Systematic Diseases	
☐ Lazy Eye _____	☐ Glaucoma _____	☐ Arthritis _____	☐ Kidney Disease _____
☐ Blindness _____	☐ Glaucoma Suspect _____	☐ Cancer _____	☐ Lupus _____
☐ Cataract(s) _____	☐ Macular Degeneration _____	☐ Diabetes _____	☐ Stroke _____
☐ Color Blindness _____	☐ Retinal Detachment _____	☐ Heart Disease _____	☐ Thyroid Disease _____
☐ Eye Tumors	☐ Eye Turn	☐ High Blood Pressure	☐ Other

Social History - General

Do you drink alcohol? ☐ Yes ☐ No How frequently? ☐ Occasional ☐ 1 per day ☐ 2-3 per day ☐ 4+ per day

Do you smoke? ☐ Yes ☐ No How frequently? ☐ Occasional ☐ ½ pack per day ☐ 1 pack per day ☐ 1+ pack per day

Are you a past smoker? ☐ Yes ☐ No In what year did you quit smoking? _____

Tobacco use cessation intervention, counseling? ☐ Yes ☐ No Tobacco cessation pharmacologic therapy? ☐ Yes ☐ No

Do you chew tobacco? ☐ Yes ☐ No

Do you use illegal drugs? ☐ Yes ☐ No

Ethnicity?

Take nutritional supplements (vitamins, etc.)? ☐ Yes ☐ No

Did you have a flu shot this year? ☐ Yes ☐ No

Have you ever had a pneumonia shot? ☐ Yes ☐ No

Are you fully vaccinated for COVID-19? ☐ Yes ☐ No

Social History - Vision

Computer Use? ☐ Yes ☐ No How many hours per day? _____ Do you drive? ☐ Yes ☐ No

Do you have glare problems? ☐ Yes ☐ No

Social History – Spectacles

Do you currently wear glasses? ☐ Yes ☐ No Since? ☐ Full-time ☐ Part-time ☐ Distance ☐ Close

Do you wear sunglasses? ☐ Yes ☐ No

Contact Lens History

Do you currently wear contact lenses? ☐ Yes ☐ No Since: _____

Type and brand of contact lenses: _____

How many hours/day? How many days/week? Today's wearing time:

Signature: _____

Date: _____