The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or "Obamacare" and Optometry best practices requires us to have certain health history information updated annually. This history becomes an integral part of your eye care visit. Please take a few moments to provide or update the requested information.

IF YOU NEED HELP COMPLETING THIS FORM PLEASE LET US KNOW

Chart Label

DATE_______________________

Purpose for today's visit:

EYE HEALTH HISTORY

When was your last eye exam?

____

Where? _______________

Do you wear glasses?

☐ Yes ☐ No

☐ All the time ☐ Reading Only

Do you wear contacts?

☐ Yes ☐ No

Type ___________________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No
Bloodshot Eyes	☐ Yes	☐ No	Floaters or Spots	☐ Yes	☐ No
Blurred Vision - Distance	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Blurred Vision - Near	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Itching Eyes	☐ Yes	☐ No
Color Vision, Poor	☐ Yes	☐ No	Light Sensitive	☐ Yes	☐ No
Crossed Eyes	☐ Yes	☐ No	Loss of Vision	☐ Yes	☐ No
Discharge from Eyes	☐ Yes	☐ No	Night Vision, Poor	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No	Red Eyes	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Seeing Halos	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No	Seeing Flashes	☐ Yes	☐ No
Eye Infection	☐ Yes	☐ No	Twitching Eyelid	☐ Yes	☐ No
Eye Injury	☐ Yes	☐ No	Vision Poor	☐ Yes	☐ No
Eye Strain	☐ Yes	☐ No	Watering Eyes	☐ Yes	☐ No

HEALTH HISTORY

Please provide your regular Physician's Name ______________________________

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a close blood relative has had any of the following problems.

Condition	Yourself		Family Members		Condition	Yourself		Family Members	
AIDS/HIV	☐ Yes	☐ No	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	☐ Yes	☐ No	Lazy Eye	☐ Yes	☐ No	☐ Yes	☐ No
Blindness	☐ Yes	☐ No	☐ Yes	☐ No	Lupus	☐ Yes	☐ No	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	☐ Yes	☐ No	Migraines	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	☐ Yes	☐ No
Drug Sensitivity	☐ Yes	☐ No	☐ Yes	☐ No	Retinal Disease	☐ Yes	☐ No	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	☐ Yes	☐ No	Shingles	☐ Yes	☐ No	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	☐ Yes	☐ No	Thyroid Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No	☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No		

Please tell us about your medications and allergies on the other side.

Please provide us with a list of your current medications along with any known allergies.

IF YOU NEED HELP COMPLETING THIS FORM PLEASE LET US KNOW

Chart Label

DATE

MEDICATIONS

List any medications you are currently taking, including eye drops:

____

____

____

____

____

____

____

____

____

____

____

ALLERGIES

List your allergies to medications or other substances:

____

____

____

____

____

____

____

____

____

____

____

Preferred Pharmacy ______________________________

Phone ______________________________

THANK YOU! Please return this form to the front desk.