Fidler EyeCare Confidential Health History

Clear Vision Begins With Healthy Eyes!

Name _____ Date: _____

Please check all that apply

Today's Visit: ❑ Eye Exam ❑ Contact Lenses ❑ Eye Infection or Injury
❑ Eyeglasses ❑ Glaucoma ❑ Cataract ❑ LASIK

Personal Eye Information

Do you have any eye conditions or problems? _____

Computer use per day: ❑ Occasional ❑ A few hours ❑ Many hours

❑ Wear Eyeglasses ❑ Eye Medications ❑Sensitivity to Light ❑ Eye Allergy
❑ Wear Contact lenses ❑ Itch/Burn ❑Flashes Floaters/Spots ❑ Water/Dryness
❑ Eye Surgery or Injury ❑ Cataract Surgery _____

Medical History

Are you allergic to any medications? ❑ No ❑ Yes _____

❑Heart ❑ Headaches ❑ Asthma
❑ Hypertension ❑ Allergies ❑Sinusitis
❑ Pregnant/Nursing ❑ Diabetes _____A1C_____
❑ Medications including non-prescription _____

Medical Doctor_____ Last Physical _____

Review of Systems

Do you currently, or have you ever had any problems in the following areas? ❑ NO
❑ Skin conditions ❑Neurological ❑Endocrine Thyroid ❑Ears Nose Throat ❑Fever (today)
❑ Gastrointestinal ❑ Cardiovascular ❑ Respiratory ❑ Urinary/Kidney ❑ Bones Joints
❑ Blood/Lymph ❑ Allergic/Immunologic ❑ Mental/depression

Family History

Do any eye conditions occur in your family? _____

❑ Glaucoma ❑Blindness ❑ Retinal Detachment
❑ Cataracts ❑ Macular Degeneration ❑ Blindness

Do any Medical conditions occur in your family? _____

❑ Diabetes ❑ Hypertension ❑ Other _____

Social History *Some insurance companies require that we ask these questions. This information is kept strictly confidential, however you may discuss this portion directly with the doctor if you prefer.*

❑ I would prefer to discuss my social history directly with the doctor (check box)

Do you drive? ❑ Automobile ❑Boat ❑ Motorcycle ❑ Other _____
Do you use: ❑ Tobacco products ❑ Alcohol ❑ Other drugs
Have you been exposed to: ❑STD ❑Hepatitis ❑HIV