CAMBRIDGE EYE CARE OPTOMETRISTS

Patient History Form

Patient Name _____ Health Card # _____

Address _____ City _____ Postal Code _____

Birth Date _____ Family Doctor Name _____ (Number) _____

Gender ____ Marital Status _____ Occupation _____ Employer _____

How Did You Hear About Us?_____ Email _____

Phone Home _____ Cell _____ Work _____

What is the main reason for your eye appointment? _____

☐ **Yes, I consent to receiving appointment reminders, newsletters and other electronic messages from Cambridge Eye Care Optometrists. You may withdraw at any time.**

Eye History

- ☐ I stopped wearing glasses
- ☐ I stopped wearing contact lenses
- ☐ Headaches
- ☐ Glare/light sensitivity
- ☐ Tired eyes
- ☐ Amblyopia (lazy eyes)
- ☐ Burning
- ☐ Dryness
- ☐ Watery eyes
- ☐ Eye pain and/or soreness
- ☐ Foreign body sensation
- ☐ Infection of eye or lid
- ☐ Itching
- ☐ Mucous discharge
- ☐ Drooping eyelid(s)
- ☐ Redness
- ☐ Sandy or gritty feeling
- ☐ Strabismus (crossed eye)
- ☐ Blurred vision at distance
- ☐ Blurred vision at near
- ☐ Haloes

- ☐ Double vision
- ☐ Floaters or spots
- ☐ Fluctuating vision
- ☐ Loss of vision
- ☐ Loss of side vision

I stopped wearing glasses because:

_____

_____

Glasses History

Do you wear Glasses? Yes ☐ No ☐

Contact lenses History

Do you wear contact lenses? Yes ☐ No ☐

When, approximately, was your last eye exam? _____

Where did you get your last eye exam? _____

When, approximately, was your last physical exam? _____

Who is your primary care physician?_____

Do you drink alcohol? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

Please list all medical conditions you have ever had (Diabetes, High blood pressure, Arthritis, etc.)

_____

Please list all eye conditions you have ever had (Glaucoma, Cataract, Wandering or Lazy eye, Retinal detachment):

_____

Please list any medical or eye conditions that run in your family (blood relatives) (Diabetes, High blood pressure, Cancer, Glaucoma, Macular degeneration, etc.):

_____

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Please list all hospital surgeries you have ever had:

Please list all prescription and over-the-counter medications you take and for what conditions:

Please list all drug allergies you have:

Please check off any current conditions you suffer from

- ☐ Chronic fever, unexpected weight loss/gain, fatigue
- ☐ Ear/nose/throat problems (eg. Hearing loss, sinus problems, sore throat)
- ☐ Heart problems (eg. Chest pain, irregular heart beat, swelling of feet, cold hands or feet)
- ☐ Respiratory problems (eg. Shortness of breath, wheezing, coughing)
- ☐ Gastrointestinal problems (eg. Heartburn, abdominal pain, diarrhea, vomiting)
- ☐ Genitourinary problems (eg. Painful urination, blood in urine, sex organ problems)
- ☐ Musculoskeletal problems (eg. Muscle aches, joint pain, swollen joints)
- ☐ Skin problems (eg. Rashes, excessive dryness, growths or lumps)
- ☐ Neurological problems (eg. Numbness, weakness, headaches, “blackouts”)
- ☐ Psychiatric problems (eg. Depression, anxiety)
- ☐ Endocrine problems (eg. Frequent urination, thirst, feeling hot or cold all the time)
- ☐ Blood/Lymph problems (eg. Bruising, weakness, unusual paleness, swollen glands)
- ☐ Immune problems (eg. Frequent infections, allergic reactions to foods, dust, pollens)

Please bring all insurance cards with you to your appointment.

Insurance Company Name _____

Insured's Name First Name _____ Last Name _____

Identification Number _____ Group Number _____

Insured's Date of Birth ____D/____ M/_____Y

Patient's Relation to Insured _____

Secondary Insurance

Do you have secondary insurance? Yes ☐ No ☐

During a typical day in the past month, how often did your eyes feel discomfort?

◯ Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯ Constantly

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When your eyes felt discomfort, how intense was this feeling of discomfort at the end of the day, within two hours of going to bed?

○ ○ ○ ○ ○ ○

Never Very Intense

During a typical day in the past month, how often did your eyes feel dry?

☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Constantly

When your eyes felt dry, how intense was this feeling of discomfort at the end of the day, within two hours of going to bed?

○ ○ ○ ○ ○ ○

Never Very Intense

During a typical day in the past month, how often did your eyes look or feel excessively watery?

☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Constantly