Please download this form, print it then fill it out. Once filled out, you can either email it to sandickey@theopticalhouse.com, fax it to (781) 245-4518 or bring it in with you.

Family History			**Mother, Father, Sibling(s) or Other**			
Disease/ Condition	**Yes**	**No**	**Mother**	**Father**	**Sibling(s)**	**Other**
Blindness						
Cataract						
Crossed Eyes						
Glaucoma						
Macular Degeneration						
Retinal Detachment/ Disease						
Arthritis						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure or Stroke						
Kidney Disease						
Lupus						
Thyroid Disease						
Other						

Social History						
Employed?	Fulltime		Part-time		Not Employed	
Computer Usage	Hours/Day					
Exposed to fumes, dust, chemicals?						
Do you drive?	Yes	No	Vision Problems while driving?	Yes	No	
Driving Problems?						
Foreign travel within last year						
Diseases	Gonorrhea					
	Hepatitis B or C					
	HIV Positive					
	Syphilis					
Use of Tobacco Products?	Yes	No	How long and quantity:			
Alcoholic Drinks?						
Psychological drugs?						
Caffeinated drinks?						

Patient History Form

Please fill out completely

Name:_____ **Date Of Birth:** __/__/____

NAME: _____ **DATE OF BIRTH**: __/__/____

Systemic Review	Yes	No	Head, Ears, Nose, Mouth, and Throat	Yes	No
Fevers or weight change			Allergies/ Hay Fever		
Skin problems			Coughing		
Headaches			Dryness of throat/ mouth		
Migraines			Sinus congestion		
Fainting, seizures, or strokes			Runny nose		
Eyes and Vision	**Yes**	**No**	Post-nasal drip		
Flashes/ Floaters in vision			**Lungs**	**Yes**	**No**
Tired eyes			Asthma		
Vision loss			Chronic bronchitis		
Vision blurred			Emphysema		
Distortion/ Halos			**Cardiovascular**	**Yes**	**No**
Side vision loss			Heart pain		
Double vision			High blood pressure		
Dryness			Vascular disease		
Sandy feeling			**GIS**	**Yes**	**No**
Eye itch			Diarrhea		
Mucous discharge			Constipation		
Redness			**Muscles and Joints**	**Yes**	**No**
Burning sensation			Arthritis		
Foreign body sensation			Muscle cramps or soreness		
Tearing/ Watering			Joint soreness		
Light sensitivity			ENDOCRINOLOGIC		
Eye soreness			Thyroid/ other glands		
Infections of eye or lid			Diabetes		
Sties/ Chalazion			Anemia		
PSCHIATRIC			Bleeding problems		
IMMUNOLOGIC			Height		
Weight					
Comment:					
Medications:					