

Welcome to Cherry Hills Family Eye Care. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

**Visual history**

What is the main reason for today's examination? \_\_\_\_\_

When was your last eye examination? \_\_\_\_\_

Do you have a history of any of the following?

	Yes	No		Yes	No		Yes	No
Blurred vision	___	___	Headaches	___	___	Eyes itch	___	___
Blindness	___	___	Glaucoma	___	___	Eyes burn	___	___
Eye turn (strabismus)	___	___	Cataracts	___	___	Eyes water	___	___
Lazy eye (amblyopia)	___	___	Double vision	___	___	Eyes feel dry	___	___
Macular degeneration	___	___	Flashing lights	___	___	Eyes feel gritty	___	___
Retinal detachment	___	___	Frequent Styes	___	___	Eyes are red	___	___
Halos around lights	___	___	Floaters	___	___	Eyes hurt/tired	___	___
Bothered by lights	___	___	Keratoconus	___	___			

Do you currently wear glasses? \_\_\_Yes\_\_\_No

Do you currently wear contact lenses? \_\_\_Yes\_\_\_No

How often do you replace your contact lenses? \_\_\_Daily disposable \_\_\_2 Weeks \_\_\_3 weeks  
 \_\_\_Monthly \_\_\_Quarterly \_\_\_When they feel bad

How old is your current pair? \_\_\_\_\_

Are your contact lenses comfortable? \_\_\_Yes\_\_\_No

Do you see well with them? \_\_\_Yes\_\_\_No

Please list any eye surgeries \_\_\_\_\_

Please list any eye drops that you use \_\_\_\_\_

Please list any other eye disease or condition \_\_\_\_\_

**Medical history / Review of systems**

Physician's name \_\_\_\_\_ Last examination \_\_\_\_\_

Please list any medications you are taking \_\_\_\_\_

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Are you pregnant or nursing? \_\_\_Yes\_\_\_No

Do you have a history of any of the following?

	Yes	No		Yes	No		Yes	No
High blood pressure	___	___	Migraines	___	___	Arthritis	___	___
Thyroid disease	___	___	Stroke	___	___	Cancer	___	___
Allergies/Hay fever	___	___	Diabetes	___	___	Asthma	___	___
Multiple sclerosis	___	___	Emphysema	___	___	Anemia	___	___

Please explain \_\_\_\_\_

### Family History

Any history of the following in any family members?

	Yes	No		Yes	No		Yes	No
Macular degeneration	___	___	Cancer	___	___	Blindness	___	___
Eye turn (strabismus)	___	___	Diabetes	___	___	Glaucoma	___	___
Lazy eye (eye turn)	___	___	Stroke	___	___	Cataracts	___	___
High blood pressure	___	___	Poor vision	___	___	Other	___	___
Retinal detachment	___	___	Please explain _____					

### Social History (confidential)

How often to you use tobacco products? \_\_\_Never \_\_\_Less than pack/day \_\_\_1 pack/day \_\_\_2+ packs/day

How often do you consume alcohol? \_\_\_Never \_\_\_Occasionally \_\_\_1 drink/day \_\_\_2+ drinks/day

Do you have: \_\_\_Hepatitis \_\_\_HIV \_\_\_Sexually transmitted diseases

Please list any hobbies \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_