Welcome to SOMERSET OPHTHALMOLOGY

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PLEASE PRINT

Name_____

Date of Birth_____

EYE HEALTH HISTORY

Date of last eye exam _____

Name of Doctor _____

Do you wear glasses? ☐ Yes ☐ No All the time ☐ Occasionally ☐ Reading ☐ Driving ☐ TV ☐

Do you wear contacts/ ☐ Yes ☐ No Type _____ Hours per day _____

Is your visit for the purpose of obtaining contact lenses? _____

Describe any problems you are having with your contacts. _____

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

(OVER)

Health History

Place a mark on “yes” or “no: to indicate if you have had nay of the following. Also place a mark to indicate if a blood relation has had any of the following problems.

	YOURSELF	FAMILY MEMBER		YOURSELF	FAMILY MEMBER
AIDS/HIV	☐ Yes ☐ No	☐ Yes ☐ No _____	Hepatitis (Type_____)	☐ Yes ☐ No	☐ Yes ☐ No _____
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No _____	High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No _____
Artificial Heart Valve	☐ Yes ☐ No	☐ Yes ☐ No _____	Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No _____
Artificial Joints	☐ Yes ☐ No	☐ Yes ☐ No _____	Lazy Eye	☐ Yes ☐ No	☐ Yes ☐ No _____
Asthma	☐ Yes ☐ No	☐ Yes ☐ No _____	Lupus	☐ Yes ☐ No	☐ Yes ☐ No _____
Bleeding	☐ Yes ☐ No	☐ Yes ☐ No _____	Migraine Headaches	☐ Yes ☐ No	☐ Yes ☐ No _____
Blindness	☐ Yes ☐ No	☐ Yes ☐ No _____	Pacemaker	☐ Yes ☐ No	☐ Yes ☐ No _____
Cancer	☐ Yes ☐ No	☐ Yes ☐ No _____	Poor Color Vision	☐ Yes ☐ No	☐ Yes ☐ No _____
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No _____	Retinal Disease	☐ Yes ☐ No	☐ Yes ☐ No _____
Chemical Dependency	☐ Yes ☐ No	☐ Yes ☐ No _____	Rheumatic Fever	☐ Yes ☐ No	☐ Yes ☐ No _____
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No _____	Shingles	☐ Yes ☐ No	☐ Yes ☐ No _____
Drug Sensitivity	☐ Yes ☐ No	☐ Yes ☐ No _____	Skin Conditions	☐ Yes ☐ No	☐ Yes ☐ No _____
Emphysema	☐ Yes ☐ No	☐ Yes ☐ No _____	Stroke	☐ Yes ☐ No	☐ Yes ☐ No _____
Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No _____	Thyroid Conditions	☐ Yes ☐ No	☐ Yes ☐ No _____
Eye Surgery	☐ Yes ☐ No	☐ Yes ☐ No _____	Tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No _____
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No _____	Turned Eye	☐ Yes ☐ No	☐ Yes ☐ No _____
Hay Fever	☐ Yes ☐ No	☐ Yes ☐ No _____	Are you Pregnant?	☐ Yes ☐ No	# Children _____
Heart Condition	☐ Yes ☐ No	☐ Yes ☐ No _____	Tobacco Use	☐ Yes ☐ No	_____
			Alcohol Use	☐ Yes ☐ No	_____

_____ _____

Patients Signature Date

MAIN PHARMACY:

Name (i.e. CVS, Rite-Aid, etc.): _____

Street Name & City: _____

Phone: _____ Fax:

MAIL ORDER:

_____ Medco _____Caremark

_____ Express Scripts, Inc. _____Pharmacare

_____ _____

Physician Signature Date