Patient History Form

Renewal OPTOMETRY, LLC

General

Name: _____

Date of Birth: _____ Gender & Pronouns:_____

Social Security #: _____ Ethnicity:_____

Address: _____

_____

Lifestyle

Job Title: _____

Employer: _____

Full-time or Part-time: _____

Hobbies: _____

Alcohol Use:	Y	N	How often? _____	How long? _____
Tobacco Use:	Y	N	How often? _____	How long? _____
Illicit Drug Use:	Y	N	How often? _____	How long? _____

Health History

PCP: _____ Previous Eye Dr: _____

Last PCP Visit: _____ Last Eye Exam: _____

Medical Diagnoses:

Cancer:	Y	N	Hypertension:	Y	N
Heart Disease:	Y	N	Autoimmune:	Y	N
Stroke:	Y	N	Thyroid Disease:	Y	N
Diabetes:	Y	N	Other: _____		

General Surgeries (w/Estimated Date):

_____

_____

_____

Ocular Diagnoses:

Glaucoma:	Y	N	Cataracts:	Y	N
Macular			Glasses Use:	Y	N
Degeneration:	Y	N	Contact Lens Use:	Y	N
Amblyopia:	Y	N	Other: _____		

Ocular Surgeries (w/Estimated Date):

_____

_____

_____

Medications (including OTC, Vitamins, and Supplements):

_____

_____

_____

Ocular Medications (including OTC drops):

_____
_____
_____
_____

Allergies:_____
_____
_____

History of Brain Injury:

Traumatic:	Y	N	Date:_____
Acquired:	Y	N	Date:_____

Current Therapies:

_____
_____
_____

Previous Therapies:

_____
_____
_____

Family History:

Glaucoma:	Y	N	Cancer:	Y	N
Macular Degeneration:	Y	N	Stroke:	Y	N
Amblyopia (Lazy Eye):	Y	N	Diabetes:	Y	N
Strabismus (Eye Turn):	Y	N	Heart Disease:	Y	N

Reason For Exam:

_____
_____
_____

Referred By:

_____

Communication:

Email: _____ Phone #: _____

Preferred Method of Communication: Text ____ Phone Call _____ Email _____ Mail _____

Other:

Parent/Guardian:_____

P/G Phone #: _____

P/G Address: _____
_____