HIGGINS BROTHERS VISION CARE

# PATIENT INTAKE FORM

Name: _____ Today's Date: _____
Address: _____ Phone: _____
City: _____ Zip: _____ Work Phone: _____
E-mail address: _____ Cell Phone: _____
Guardian (If Applicable): _____ BirthDate: _____
How did you find us / Referred by: _____ Occupation: _____
Name of Medical Doctor: _____ Doctor's Phone: _____

**Medical History: Last medical examination?** _____

**Do you have any allergies to medications?** No ☐ Yes ☐ If yes, explain: _____

List any medications (including oral contraceptives, aspirin, over the counter medications and home remedies or nutraceuticals (vitamins, herbal supplements) you take: _____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Circle any of the following conditions thafrelate to you: dry eye, Sjogren's syndrome, crossed eyes, lazy eye, Graves' disease, drooping eyelid, glaucoma, retinal disease, cataracts, macular degeneration, uveitis, eye infections, or eye injuries Are you pregnant and/or nursing? No ☐ Yes ☐

Do you wear Glasses? No ☐ Yes ☐ If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No ☐ Yes ☐ If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐ rigid ☐ soft ☐ extended wear ☐ other Are they comfortable? ☐ no ☐ yes

## Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased?) for the following conditions:

| DISEASE/CONDITION | NO | YES | ? | RELATIONSHIP TO YOU |
|---|---|---|---|---|
| Blindness | ☐ | ☐ | ☐ | _____ |
| Cataract | ☐ | ☐ | ☐ | _____ |
| Crossed Eyes | ☐ | ☐ | ☐ | _____ |
| Glaucoma | ☐ | ☐ | ☐ | _____ |
| Macular Degeneration | ☐ | ☐ | ☐ | _____ |
| Retinal Detachment / Disease Arthritis | ☐ | ☐ | ☐ | _____ |
| Cancer | ☐ | ☐ | ☐ | _____ |
| Diabetes | ☐ | ☐ | ☐ | _____ |
| Heart Disease | ☐ | ☐ | ☐ | _____ |
| High Blood Pressure Kidney Disease | ☐ | ☐ | ☐ | _____ |
| Lupus | ☐ | ☐ | ☐ | _____ |
| Thyroid Disease | ☐ | ☐ | ☐ | _____ |

Other: _____

_____

## Social History

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Do you drive? ☐ no ☐ yes If yes, type/ amount I how many hours per day: _____

Do you use a computer? ☐ no ☐ yes If yes, type/ amount/ how many hours per day: _____

Do you smoke? ☐ no ☐ yes If yes, how much? _____ how long? _____

Do you drink alcohol? ☐ no ☐ yes If yes, type/ amount/ how often: _____

Do you use illegal drugs? ☐ no ☐ yes If yes, type/ amount/ how often: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

## Review of Systems

Do you currently, or have you ever had any problems in the following areas:

| SYSTEM | NO | YES | ? |
|---|---|---|---|
| **CONSTITUTIONAL** Fever, Weight Loss I Gain | ☐ | ☐ | ☐ |
| **INTEGUMENTARY (Skin)** | ☐ | ☐ | ☐ |
| **NEUROLOGICAL** Headaches Migraines / with aura Seizures | ☐ | ☐ | ☐ |
| **EYES** | | | |
| Loss of Vision | ☐ | ☐ | ☐ |
| Blurred Vision | ☐ | ☐ | ☐ |
| Distorted Vision / Halos | ☐ | ☐ | ☐ |
| Loss of Side Vision | ☐ | ☐ | ☐ |
| Double Vision | ☐ | ☐ | ☐ |
| Dryness | ☐ | ☐ | ☐ |
| Burning or Stinging | ☐ | ☐ | ☐ |
| Mucous Discharge | ☐ | ☐ | ☐ |
| Redness | ☐ | ☐ | ☐ |
| Sandy or Gritty Feeling | ☐ | ☐ | ☐ |
| Itching | ☐ | ☐ | ☐ |
| Foreign Body Sensation | ☐ | ☐ | ☐ |
| Excess Tearing/ Watering | ☐ | ☐ | ☐ |
| Glare / Light Sensitivity | ☐ | ☐ | ☐ |
| Eye Pain or Soreness | ☐ | ☐ | ☐ |
| Chronic Infection of Eye or Lid | ☐ | ☐ | ☐ |
| Sties or Chalazion | ☐ | ☐ | ☐ |
| Flashes or Floaters | ☐ | ☐ | ☐ |
| Tired Eyes | ☐ | ☐ | ☐ |

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____

_____

| | NO | YES | ? |
|---|---|---|---|
| **EARS, NOSE, MOUTH, THROAT** | | | |
| Allergies/ Hay | ☐ | ☐ | ☐ |
| Fever | ☐ | ☐ | ☐ |
| Sinus Congestion | ☐ | ☐ | ☐ |
| Runny Nose | ☐ | ☐ | ☐ |
| Post-Nasal Drip | ☐ | ☐ | ☐ |
| Chronic Cough | ☐ | ☐ | ☐ |
| Dry Throat / Mouth | ☐ | ☐ | ☐ |
| **RESPIRATORY** | | | |
| Asthma | ☐ | ☐ | ☐ |
| Sleep Apnea | ☐ | ☐ | ☐ |
| Chronic Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| **VASCULAR/ CARDIOVASCULAR** | | | |
| Diabetes | ☐ | ☐ | ☐ |
| Heart Pain | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ |
| Vascular Disease | ☐ | ☐ | ☐ |
| Raynaud's Disease | ☐ | ☐ | ☐ |
| **GASTROINTESTINAL** | | | |
| Diarrhea | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| **BONES/ JOINTS/ MUSCLES** | | | |
| Rheumatoid Arthritis | ☐ | ☐ | ☐ |
| Lyme Disease | ☐ | ☐ | ☐ |
| Muscle Pain | ☐ | ☐ | ☐ |
| Joint Pain | ☐ | ☐ | ☐ |
| **LYMPHATIC/ HEMATOLOGIC** | | | |
| Anemia | ☐ | ☐ | ☐ |
| Bleeding Problems | ☐ | ☐ | ☐ |
| **ALLERGIC / IMMUNOLOGIC** | ☐ | ☐ | ☐ |
| **PSYCIDATRIC** | ☐ | ☐ | ☐ |

Doctor's Signature _____ Date _____