



WELCOME!

Thank you for choosing the Stine Eye Center for your vision and eye health needs. We are a health-centered Optometric practice, thus we ask that you fill out this health questionnaire completely – even if some of the questions may not seem relevant to your visual health. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ DOB _____ Today's Date _____

Reason for Visit _____

Date of last eye exam _____ By Whom _____ Date of last pupil dilation _____

Date of last physical examination _____ By Whom _____

Do you currently wear Glasses? yes no Contacts? yes no

FAMILY HISTORY – Has anyone in your family history ever been diagnosed with:

Symptom	Yes	No	Please list whom:
Cataract			
Glaucoma			
Hypertension (high blood pressure)			
Thyroid dysfunction			
Blindness			
Lazy eye			
Diabetes			
Macular Degeneration			

VISION HEALTH

– Are you currently or have you in the past experienced:

Symptom	In the Past		Currently		Symptom	In the Past		Currently		Symptom	In the Past		Currently	
	Yes	No	Yes	No		Yes	No	Yes	No		Yes	No	Yes	No
Blurred vision w/correction					Headaches					Cataract				
Blurred vision w/o correction					Dry eye					Glaucoma				
Eye pain or discomfort					Red eye					Macular degeneration				
Eyes burn, itch or water					Floaters or spots					Crossed eye / lazy eye				
Eye allergies					Double vision					Eye infection or disease				
Night glare or reflections					Flashes of light					Eye injury or surgery				
Sensitivity to light					Discharge from eyes					Date: _____ Type: _____				

Please list all medications you are ALLERGIC TO:

Medication	Reaction	Office Use Only

Please list all medications and eye drops you are CURRENTLY TAKING:

Medication	Dosage	Reason	Office Use Only

GENERAL HEALTH – Are you currently or have you in the past experienced:

Cardiovascular Concerns:	Yes	No	Genitourinary Concerns:	Yes	No	Allergic / Immunologic Concerns:	Yes	No
Heart Disease / Heart Surgery			Pregnancy or Nursing			Environmental Allergies		
Heart Attack / Stroke			Childbirth in the last 6 months			Seasonal Allergies		
High Blood Pressure			Urinary Tract Infection			Eczema		
High Cholesterol			Chlamydia			Lupus		
Large Volume Blood Loss			Herpes History			Sjogrens		
Vascular Disease			Other			Ankylosing Spondylitis		
Other						Other		
Respiratory Concerns:	Yes	No	Neurological Concerns:	Yes	No	Psychiatric Concerns:	Yes	No
Asthma			Epilepsy			Depression or Anxiety		
COPD			Multiple Sclerosis			Panic Disorders		
Respiratory Tract Infection			Muscular Dystrophy			Schizophrenia		
Bronchitis			Other			Fainting Spells		
Emphysema						Cognitive Delay		
Other						Other		
Ear, Nose, or Throat Concerns:	Yes	No	Gastrointestinal Concerns:	Yes	No	Hematologic/Lymphatic Concerns:	Yes	No
Xerostomia / Dry Mouth			Colitis			Enemia		
Oral Cancer			Crohn's Disease			Blood Disorder		
Vertigo			Ulcer			Leukemia		
Sinus Infection			Other			Other		
Hearing Difficulties								
Other								
Endocrine Concerns:	Yes	No	Constitutional Concerns:	Yes	No	Social Concerns:	Yes	No
Diabetes IDDM or NIDDM			Unexplained Weight Loss			Smoking		
Thyroid Dysfunction			Unexplained Fever			Alcohol Consumption		
Hormone Replacement Therapy			Fatigue/ Malaise			Lack of Exercise		
Hormone Dysfunction			Other			Other		
Other								
Integumentary Skin/Breast Concerns:	Yes	No	Musculoskeletal Concerns:	Yes	No	Other Concern(s) Not Noted Above:	Yes	No
Rosacea			Physical Disability					
Cancer			Fibromyalgia					
Skin Cancer			Developmental Delay					
Eczema			Wheel Chair Required					
Psoriasis			Other					
Other								

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I will notify the Stine Eye Center immediately of any changes in my vision, health or medication(s).

Signature of patient (or parent / guardian if a minor): _____ Date: _____

MEDICAL HISTORY REVIEWED WITH PATIENT / PARENT:

Today's Date:	Staff Initials:	Patient Health History: <input type="checkbox"/> No changes <input type="checkbox"/> Changes noted above Family History: <input type="checkbox"/> No changes <input type="checkbox"/> Changes noted above Social History: <input type="checkbox"/> No changes <input type="checkbox"/> Changes noted above	Patient, Parent or Guardian Signature:
Today's Date:	Staff Initials:	Patient Health History: <input type="checkbox"/> No changes <input type="checkbox"/> Changes noted above Family History: <input type="checkbox"/> No changes <input type="checkbox"/> Changes noted above Social History: <input type="checkbox"/> No changes <input type="checkbox"/> Changes noted above	Patient, Parent or Guardian Signature:
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