Stine Eye Center
EYE CARE & EYE WEAR

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			
Other			

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

Symptom	In the Past		Currently	
	Yes	No	Yes	No
Blurred vision w/correction				
Blurred vision w/o correction				
Eye pain or discomfort				
Eyes burn, itch or water				
Eye allergies				
Night glare or reflections				
Sensitivity to light				

Symptom	In the Past		Currently	
	Yes	No	Yes	No
Headaches				
Dry eye				
Red eye				
Floaters or spots				
Double vision				
Flashes of light				
Discharge from eyes				

Symptom	In the Past		Currently	
	Yes	No	Yes	No
Cataract				
Glaucoma				
Macular degeneration				
Crossed eye / lazy eye				
Eye infection or disease				
Eye injury or surgery				
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			Lupus		
High Cholesterol			Chlamydia			Sjogrens		
Large Volume Blood Loss			Herpes History			Ankylosing Spondylitis		
Vascular Disease			Prostate			Other		
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			Concussion			Fainting Spells		
Emphysema			Traumatic Brain Injury			Cognitive Delay		
Sleep Apnea			Other			Other		
Ear, Nose, or Throat Concerns:	**Yes**	**No**	**Gastrointestinal Concerns:**	**Yes**	**No**	**Hematologic/Lymphatic Concerns:**	**Yes**	**No**
Xerostomia / Dry Mouth			Celiac			Anemia		
Oral Cancer			Colitis			Blood Disorder		
Vertigo			Crohn's Disease			Leukemia		
Sinus Infection			Ulcer			Other		
Hearing Difficulties			Other					
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			Body Aches			Other		
Other			Tick Bite(s)					
Integumentary Skin/Breast Concerns:	**Yes**	**No**	**Musculoskeletal Concerns:**	**Yes**	**No**	**Other Concern(s) Not Noted Above:**	**Yes**	**No**
Rosacea			Physical Disability			COVID-19		
Cancer			Fibromyalgia			Shingles		
Skin Cancer			Developmental Delay			HIV / AIDS		
Eczema			Wheel Chair Required			Organ Transplant		
Psoriasis			Arthritis			Migraines		
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, Parent or Guardian Signature:
		Patient Health History: ☐ No changes ☐ Changes noted above **Family History:** ☐ No changes ☐ Changes noted above **Social History:** ☐ No changes ☐ Changes noted above	

Today's Date:	Staff Initials:		Patient, Parent or Guardian Signature:
		Patient Health History: ☐ No changes ☐ Changes noted above **Family History:** ☐ No changes ☐ Changes noted above **Social History:** ☐ No changes ☐ Changes noted above	

Today's Date:	Staff Initials:		Patient, Parent or Guardian Signature:
		Patient Health History: ☐ No changes ☐ Changes noted above **Family History:** ☐ No changes ☐ Changes noted above **Social History:** ☐ No changes ☐ Changes noted above	

Today's Date:	Staff Initials:		Patient, Parent or Guardian Signature:
		Patient Health History: ☐ No changes ☐ Changes noted above **Family History:** ☐ No changes ☐ Changes noted above **Social History:** ☐ No changes ☐ Changes noted above	