

# Patient Health Information

## Mason Family Eye Care

<b>Name:</b> _____		<b>Date:</b> _____
Birth Date: _____	Social Security Number _____	E-mail address _____
Address, City, State, Zip _____	Home Telephone: _____	Married   Single   Divorced   Widow   Other
	Work Telephone: _____	Caucasion   African American   Hispanic   Other

*Thank you for taking the time to carefully complete the patient health information form. This information will be reviewed by the doctor during your examination. All information provided will be held in strict confidence.*

### Medical History

- ◆ List medications you are currently taking (prescription and over-the-counter.) \_\_\_\_\_
- ◆ Do you have any allergies to medications?   **Y**   **N**   If yes, please list \_\_\_\_\_
- ◆ List major illnesses, injuries, and surgeries you have had. \_\_\_\_\_
- ◆ Name and office location of your medical doctor(s). \_\_\_\_\_
- ◆ Date of your last physical examination. \_\_\_\_\_
- ◆ Height (approximate) \_\_\_\_\_      Weight (approximate) \_\_\_\_\_

<ul style="list-style-type: none"> <li>◆ Do you wear glasses?   <b>Y</b>   <b>N</b></li> <li>◆ When do you wear your glasses? _____</li> <li>◆ How old are your glasses? _____</li> <li>◆ What type of glasses? Single      Bifocal      Trifocal      Progressive</li> </ul>	<ul style="list-style-type: none"> <li>◆ Date of last complete eye exam. _____</li> <li>◆ Are you pregnant/nursing?   <b>Y</b>   <b>N</b></li> <li>◆ Have you worn contact lenses?   <b>Y</b>   <b>N</b></li> <li>◆ Do you now wear contact lenses?   <b>Y</b>   <b>N</b></li> <li>◆ What type of lens? Hard/RGP      Soft      Extended      Bifocal</li> </ul>
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### Family History *Please note any family members with the following conditions.*

Condition	Yes	No	Unsure	Relationship
◆ Blindness				
◆ Glaucoma				
◆ Macular degeneration				
◆ Arthritis				
◆ Cancer				
◆ Diabetes				
◆ Heart Disease				
◆ High Blood Pressure				
◆ Other				

### Social History

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

List your hobbies/ recreational activities. \_\_\_\_\_

Do your occupation or hobbies/ recreational activities require the use of safety eyewear?   **Y**   **N**

Do you use a computer at work or at home? <b>Y</b> <b>N</b>	Do you Drink alcohol? <b>Y</b> <b>N</b> If yes, how often? _____
Do you drive? <b>Y</b> <b>N</b> If yes, do you have visual difficulty when driving? <b>Y</b> <b>N</b>	Have you ever been exposed to HIV? <b>Y</b> <b>N</b>
Do you use tobacco products? <b>Y</b> <b>N</b> If yes, what amount/ how long? _____	Have you ever been exposed to TB? <b>Y</b> <b>N</b>

## **Current Symptoms and Diagnosed Conditions**

<i>Condition</i>	<i>Yes</i>	<i>No</i>	<i>If yes, please explain</i>
Eye injury, pain, or surgery			
Loss of vision			
Blurred vision			
Tired eyes			
Redness			
Itching			
Burning			
Sandy or dry eyes			
Excessive tears (watery eyes)			
Vision disturbance			
Light sensitivity/ glare			
Double vision			
Glaucoma			
Cataract			
Macular Degeneration			
Diabetic retinopathy			
Amblyopia (lazy eye)			
Eye-turn (eso- or exotropia)			
Keratoconus (cornea disease)			
Constitutional (fever , weight loss)			
Ears, nose, mouth, throat			
Respiratory (asthma, emphysema, etc)			
Cardiovascular (high blood pressure, vascular disease, etc)			
Gastrointestinal (diarrhea, constipation, ulcers, etc)			
Genitourinary (genitals, kidney, bladder)			
Muscles/ bones/ joints (arthritis, etc)			
Endocrine (diabetes, thyroid, etc)			
Psychiatric (bi-polar, depression, ADD, schizophrenia, etc)			
Blood, Lymph (anemia, high cholesterol, etc)			
Allergic/ Immunologic (hay fever, lupus, etc)			
Skin			
Neurological (headaches, multiple sclerosis, etc)			

*I am responsible for payment at the time of each visit for all services provided by Dr. Linsley, not covered by insurance. My signature serves as a "signature on file" for claims processing and for release of medical information to my insurance carrier and medical consultants.*

\_\_\_\_\_  
*Signature of patient or person authorized to sign for patient*

\_\_\_\_\_  
*Date*