VISION SOURCE

Patient Health Information
Mason Family Eye Care

Name:		**Date:**
Birth Date:	Social Security Number	E-mail address
Address, City, State, Zip	Home Telephone: Work Telephone:	Married Single Divorced Widow Other Caucasian 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) _____

Do you wear glasses? **Y** **N** When do you wear your glasses? _____ How old are your glasses? _____ What type of glasses? Single Bifocal Trifocal Progressive	Date of last complete eye exam._____ Are you pregnant/nursing? **Y** **N** Have you worn contact lenses? **Y** **N** Do you now wear contact lenses? **Y** **N** What type of lens? Hard/RGP Soft Extended Bifocal

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? **Y** **N**	Do you Drink alcohol? **Y** **N** If yes, how often? _____
Do you drive? **Y** **N** If yes, do you have visual difficulty when driving? **Y** **N**	Have you ever been exposed to HIV? **Y** **N**
Do you use tobacco products? **Y** **N**	Have you ever been exposed to TB? **Y** **N**

If yes, what amount/ how long? _____	

Current Symptoms and Diagnosed Conditions

Condition	*Yes*	*No*	*If yes, please explain*
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*