NASA VISION CENTER

HEALTH HISTORY

PATIENT NAME: ____ **DATE:**__________________________

ACCOUNT NO: ______________________________

Chief Complaint

How can we help you today? In this space please briefly tell us any signs and symptoms you are experiencing. (Medical insurance will only cover if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, eye itching or burning, glaucoma, cataracts, floaters, dry eyes.)

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Ocular History

Are you having any problems with your current contact lenses or glasses? Explain ________________________

When was your last eye exam? ________________________ Who was the doctor? ________________________

Do you wear glasses? Yes ___ No ___ How old are they? ________________________

Do you wear contact lenses? Yes ___ No ___ What kind? ________________________

How old are your contact lenses? ______________________ Do you sleep in them? ______________________

Medical History

List any medications you take and for what illness (including aspirin, oral contraceptives, over the counter meds, home remedies etc.)

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Do you have any allergies to medications? Yes ____ No ____Which____________________________________

Past History

List all major injuries, surgeries and/or hospitalizations____

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Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?

	Relationship
Blindness	[]____
Cataracts	[]____
Corneal Problems	[]____
Glaucoma	[]____
Eye Surgery	[]____
Lazy Eye	[]____
Macular Degeneration	[]____
Color blindness	[]____
Retinal Problems	[]____
Crossed eyes	[]____
Diabetes	[]____
Heart Disease	[]____
High blood pressure	[]____
Arthritis	[]____
Thyroid	[]____
Cancer	[]____
Other	[]____

Review or Systems-Do you have a problem with…

Eyes	Y	N
Blindness	[]	[]
Loss of vision	[]	[]
Distorted vision	[]	[]
Blurred vision	[]	[]
Double vision	[]	[]
Cataracts	[]	[]
Crossed eyes	[]	[]
Flashes/floaters	[]	[]
Dry eyes	[]	[]
Watery eyes	[]	[]
Red eyes	[]	[]
Burning/itching	[]	[]
Mucous discharge	[]	[]
Sandy/gritty feeling	[]	[]
Eye pain/ soreness	[]	[]
Glare/light sensitivity	[]	[]
Chronic eye infection	[]	[]
Tired eyes	[]	[]
Halos	[]	[]
Vision Therapy	[]	[]
Eye surgery	[]	[]
Eye injury	[]	[]
Retinal detachment	[]	[]

Allergic/Immunologic	Y	N
Hay fever	[]	[]
Medicine allergies	[]	[]
Sinus problems	[]	[]
Chronic cough	[]	[]
Dry throat/mouth	[]	[]
Chronic ear infections	[]	[]
Constitutional symptoms		
Heart pain	[]	[]
High blood pressure	[]	[]
Vascular disease	[]	[]
Endocrine		
Frequent urination	[]	[]
Thirsty all the time	[]	[]
Diabetes	[]	[]
Thyroid problems	[]	[]
Other problems	[]	[]
Other glands	[]	[]
Gastrointestinal		
Diarrhea	[]	[]
Constipation	[]	[]
Ulcers	[]	[]
Genitourinary		
Genitals	[]	[]
Kidneys	[]	[]
Bladder	[]	[]

Hematologic/lymphatic	Y	N
Anemia	[]	[]
Bleeding Problems	[]	[]
Swelling	[]	[]
Integumentary	[]	[]
Skin	[]	[]
Breast	[]	[]
Musculoskeletal		
Arthritis	[]	[]
Rheumatoid Arthritis	[]	[]
Muscle pain	[]	[]
Joint pain	[]	[]
Headaches	[]	[]
Neurological		
Migraines	[]	[]
Seizures	[]	[]
Psychiatric		
Nervous disorder	[]	[]
Depression	[]	[]
Compulsive behavior	[]	[]
Respiratory		
Asthma	[]	[]
Shortness of breath	[]	[]
Emphysema	[]	[]
Lung Cancer	[]	[]

Social History

This is confidential and may be discussed directly with the doctor if so desired.

Do you use any of the following products?
Past or Current Activities

Tobacco	Yes ___	No ___
Alcohol	Yes ___	No ___
Illegal Drugs	Yes ___	No ___

Have been exposed to or infected with?

Gonorrhea	Yes ___	No ___
Hepatitis	Yes ___	No ___
HIV	Yes ___	No ___
Syphilis	Yes ___	No ___

Doctor Signature ______________________________________Date______________