Dr. Pierzchala & Associates – Welcome to Our Office

PATIENT HISTORY FORM

Patient Name_____BIRTH DATE_____TODAY'S DATE_____
Address_____City_____State_____ZIP_____
Home Phone_____Work/CellPhone_____EMAIL:_____
Your Occupation ***OR*** Students: Your Current Grade in School_____
Visual Needs at Work_____Sports/Hobbies_____
Eye Care (Vision) Insurance_____ID#_____
Medical / Health Insurance_____ID#_____Social Security#_____

Date of Last Eye Exam_____Name of Eye Doctor_____
Reason for Today's Exam_____
Do you wear Eyeglasses?_____ Do you wear Contact Lenses now or previously?_____CL Brand_____
Disinfection Solution_____
How often do you dispose of your Contacts?_____
Do you sleep in your contact lenses?_____
Would you like a trial pair of Contact Lenses, ***Bifocal*** Contact Lenses or Colored Contact Lenses ?_____
Family Doctor Name & Address_____
How did you hear about our practice?_____

GENERAL HEALTH AND EYE HEALTH HISTORY

Please check all that apply and fill out COMPLETELY as many health problems and medications affect the eyes

	SELF	FAMILY		SELF	FAMILY		SELF	FAMILY
Astigmatism	___	___	Seeing Floaters / Spots	___	___	Head Injury	___	___
Blindness	___	___	Seeing Halos	___	___	Heart Attack	___	___
Blurred Vision	___	___	Temp. Loss of Vision	___	___	Heart Condition / Angina	___	___
Burning Eyes	___	___	Trouble Night Driving	___	___	Hepatitis (Type_____)	___	___
Cataracts	___	___	Watering or Itchy Eyes	___	___	High Blood Pressure	___	___
Discharge from Eyes	___	___				Hypoglycemia	___	___
Double Vision	___	___	AIDS / HIV	___	___	Kidney Disease	___	___
Dry Eyes	___	___	Anxiety	___	___	Lupus	___	___
Eye Infection	___	___	Arthritis	___	___	Lyme Disease	___	___
Eye Injury	___	___	Asthma	___	___	Migraine Headache	___	___
Eye Surgery	___	___	Bleeding Disorder	___	___	Multiple Sclerosis	___	___
Glare	___	___	Cancer (Type_____)	___	___	Pacemaker	___	___
Glaucoma	___	___	Chemical/Alcohol depend.	___	___	Pregnant or Nursing	___	___
Lazy / Crossed Eye	___	___	Cholesterol	___	___	Rheumatic Fever	___	___
Light Sensitive	___	___	Depression	___	___	Sarcoidosis	___	___
Loss of Vision	___	___	Diabetes	___	___	Shingles	___	___
Macular Degeneration	___	___	Drug Allergy	___	___	Skin Condition	___	___
Poor Color Vision	___	___	Emphysema	___	___	Smoker	___	___
Retinal Disease	___	___	Epilepsy	___	___	Stroke	___	___
Retinal Detachment	___	___	Hay Fever / Allergies	___	___	Thyroid Condition	___	___
Seeing Flashes	___	___	Headaches	___	___	Tuberculosis	___	___

List any other medical conditions that you have_____

MEDICATIONS	ALLERGIES
List ***ALL*** medications you are currently taking, **including eyedrops** (Prescription AND Non-prescription)	List your allergies to medications or other substances:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____