# Medical and Visual Health History

Reason for today's visit: ____________________

**Last vision exam:** ____________ **Results/Findings:** ☐ **Glasses,** ☐ **Contacts,** ☐ **Cataracts,** ☐ **Glaucoma,** ☐ **Other** ____________

Patient wears: ☐ Glasses ☐ Contacts (☐ soft ☐ RGP) ☐ full time ☐ driving or watching TV only ☐ reading only ☐ occasionally

Has the patient ever had eye surgery? ☐ No ☐ Yes if yes, please describe: ____________

Has the patient ever had an eye injury? ☐ No ☐ Yes if yes, please describe: ____________

Does this patient use: Tobacco? ☐ No ☐ Yes; Alcohol? ☐ No ☐ Light ☐ Moderate; Recreational Drugs? ☐ No ☐ Yes

Is the patient currently experiencing any of the following symptoms? (Check all that apply):

- ☐ Blurry vision far away
- ☐ Blurry vision up close (reading)
- ☐ Difficulty reading
- ☐ Unusual blinking or eye rubbing
- ☐ Watering or bloodshot eyes
- ☐ Pain in or around eyes
- ☐ Itchy feeling in or around eyes
- ☐ Light sensitivity
- ☐ Double vision
- ☐ Dizziness
- ☐ Reading fatigue after 15 minutes or less
- ☐ Frequent loss of place when reading
- ☐ Poor reading comprehension
- ☐ Reversal of words, letters or numbers

Please check if the patient or a related family member has ever been diagnosed with any of the following:

| General Health | Patient | Family |
|---|---|---|
| Diabetes | ☐ | ☐ |
| High blood pressure | ☐ | ☐ |
| High cholesterol | ☐ | ☐ |
| Heart disease | ☐ | ☐ |
| Stroke / Brain injury | ☐ | ☐ |
| Headaches / Migraines | ☐ | ☐ |
| Sinus problems | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ |
| Other: ____________ | ☐ | ☐ |

| Visual Health | Patient | Family |
|---|---|---|
| Cataracts | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Amblyopia (lazy eye) | ☐ | ☐ |
| Strabismus (eye turn in or out) | ☐ | ☐ |
| Color Blindness / Deficiency | ☐ | ☐ |
| Macular Degeneration | ☐ | ☐ |
| Blindness | ☐ | ☐ |
| Retinal detachment | ☐ | ☐ |
| Other: ____________ | ☐ | ☐ |

Please indicate medications patient is currently taking or give receptionist a list to photocopy. Please also indicate any medication, food, substance and/or seasonal allergies.

| Current Medications | For what condition? |
|---|---|
| ☐ See Separate List | ☐ See Separate List |
| 1. ____________ | ____________ |
| 2. ____________ | ____________ |
| 3. ____________ | ____________ |
| 4. ____________ | ____________ |
| 5. ____________ | ____________ |
| 6. ____________ | ____________ |
| 7. ____________ | ____________ |
| 8. ____________ | ____________ |

**Allergies to Medication:**

☐ No Known Allergies

1. ____________
2. ____________
3. ____________

Seasonal Allergies? ☐ Yes ☐ No

**Food / Substance Allergies:**

1. ____________
2. ____________
3. ____________

**The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Arlington Vision Therapy or insurance company to release any information required to process my claims.**
**I also acknowledge that I received a copy of Arlington Vision Therapy's Notice of Privacy Practices.**

***Patient/Guardian signature:*** ____________ ***Date:*** ____________