Patient History Form:

Tippett Eye Care

Name (First) _____ (MI) ____ (Last)_____ Gender: M F

Address _____ City _____ State _____ Zip _____

Telephone (H) _____ (Cell/Work) _____ DOB ____/____/_____ SS# _____-____-_____

Occupation_____Employer _____

Single ☐ Married ☐ Email _____

Health Insurance Carrier_____ Vision Insurance Carrier_____

Have You ever been to this office before? ☐ **YES** ☐ **NO** When was your last Eye Examination? _____

Who may we thank for your referral? _____

Eye Health / History : (Please check all that apply) What Problems are you currently having?

☐ Blurred Vision ☐ Burning ☐ Discharge ☐ Pain/Soreness
☐ Halos/ Glare ☐ Itching ☐ Headaches ☐ Contact Lens Problems
☐ Flashes/ Floating spots ☐ Dryness ☐ Watering ☐ Peripheral Vision Loss
☐ Redness ☐ Double Vision ☐ Foreign Body sensation Other _____

Have you ever been told **YOU** have any of these? (Please check all that apply)

☐ Cataracts ☐ Glaucoma ☐ Retinal Detachment ☐ Melanoma of Eye ☐ Lazy eye ☐ Dry Eye
☐ Blindness ☐ Macular Degeneration ☐ Retinitis Pigmentosa ☐ Corneal Dystrophy ☐ Crossed eyes Other:_____

Do you now wear contact lenses? ☐ **YES** ☐ **NO** If no, have you worn them in the past? ☐ **YES** ☐ **NO**

Are you Interested in Contact lenses even for occasional use? ☐ **YES** ☐ **NO** Are you Interested in LASIK ☐ **YES** ☐ **NO**

Have You ever had an Eye injury, surgery or bad infection? ☐ **YES** ☐ **NO** Explain _____

Do you ☐ Smoke ☐ Consume Alcohol ☐ Use Recreational Drugs

PATIENT Medical History: (Please check all that apply to **YOU only**)

Constitution
☐ Developmental disability
☐ Cancer
☐ Fatigue syndrome

Cardiovascular
☐ Hypertension
☐ Stroke/CVA
☐ Heart disease
☐ Vascular disease
☐ Congestive heart failure

ENT
☐ Hearing loss
☐ Sinusitis
☐ Dry mouth
☐ Laryngitis

Hemo/Lymph
☐ Anemia
☐ Blood loss
☐ High cholesterol

Muscular/Skeletal
☐ Osteoarthritis
☐ Arthritis
☐ Fibromyalgia
☐ Muscular dystrophy
☐ Ankylosing spondylitis
☐ Osteoporosis
☐ Gout

Respiratory
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Sleep apnea

Allergy/Immune
☐ Rheumatoid arthritis
☐ Lupus
☐ Sjogren's Syndrome
☐ Seasonal allergies

Integumentary
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Cold sores
☐ Shingles

Neurological
☐ Multiple sclerosis
☐ Cerebral Palsy
☐ Tumor
☐ Migraine
☐ Headache

Psychiatric
☐ Dyslexia
☐ Depression
☐ Attention deficit
☐ Anxiety disorder
☐ Bipolar disorder
☐ Schizophrenia

Gastrointestinal
☐ Chron's
☐ Colitis
☐ Ulcer
☐ Acid reflux
☐ Celiac disease

Endocrine
☐ Type 1 Diabetes
☐ Type 2 Diabetes
☐ Thyroid dysfunction
☐ Hormone dysfunction
Other _____

FAMILY Medical History: (Please check all that apply to **Family History only**)

☐ Hypertension ☐ Blindness
☐ Cataracts ☐ High cholesterol
☐ Glaucoma ☐ Thyroid disease
☐ Macular degeneration ☐ Other _____

Are there any other conditions we should Know about? Yes ☐ No ☐

Explain _____

Are you allergic to any medications? Yes ☐ No ☐ Please List _____

Medications (Please list any current Medications you take, if you do not know the name- then what you take it for)

1._____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Tippett Eye Care

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis, whether it's caused by your eyes, posture, stress, etc. Your responses will help make sure you receive the best care possible

How often do you experience any of these symptoms? Circle the applicable response.

Headaches	• You get headaches of any severity each week (even just a dull ache counts) • Your headaches tend to get worse later in the day. 1 Never 2 Rarely 3 Sometimes 4 Very Often 5 Always
Stiffness / pain in neck / shoulders	• You experience stiffness/tension in your neck/shoulders when you work at a computer or read (this might even be from your posture). 1 Never 2 Rarely 3 Sometimes 4 Very Often 5 Always
Discomfort with Computer Use	• Your eyes get tired, burn, or get red easily when you work at a computer for long hours. 1 Never 2 Rarely 3 Sometimes 4 Very Often 5 Always
Tired Eyes	• Your eyes feel increasingly fatigued/tired as the day goes on. 1 Never 2 Rarely 3 Sometimes 4 Very Often 5 Always
Dry Eye Sensation	• Your eyes progressively feel more dry/sandy/gritty while working at the computer or reading. 1 Never 2 Rarely 3 Sometimes 4 Very Often 5 Always
Light Sensitivity	• Bright / Strong lights (vehicle headlights, fluorescent lights etc.) bother you. 1 Never 2 Rarely 3 Sometimes 4 Very Often 5 Always
Dizziness	• You experience dizziness, motion sickness, or vertigo. 1 Never 2 Rarely 3 Sometimes 4 Very Often 5 Always
Additional Notes	Any additional notes you'd like to add: