PATIENT HISTORY AND INFORMATION FORM

Please PRINT and fill out form before you arrive at our office. You can fax it to us at 509.452.7563, email it to us at info@yakimavision.com or bring it with you. This will help make the check-in process quicker and more convenient for you. Thanks and we look forward to your visit.

Yakima Vision Center
"Helping patients see better for over 20 years."
965-5200

First Name Last Name Middle

CURRENT PRIMARY CARE PHYSICIAN

Primary Care Physician Name and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam? _____

When was your last EYE exam? _____ When was your last health exam? _____

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

Current Eye Drops: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

EYE HISTORY (please circle yes or no indicating if you have had or have any of the following conditions)

Glaucoma	Yes No	Dryness	Yes No	Strabismus (Crossed Eyes)	Yes No
Cataract	Yes No	Excess Tearing/ Watering	Yes No	Blurred Vision Distance	Yes No
Macular Degeneration	Yes No	Eye Pain or Soreness	Yes No	Blurred Vision Near	Yes No
Retinal Detachment	Yes No	Foreign Body Sensation	Yes No	Distorted Vision (halos)	Yes No
Color Blindness	Yes No	Infection of Eye or Lid	Yes No	Double Vision	Yes No
Headaches	Yes No	Itching	Yes No	Floaters or Spots	Yes No
Glare/Light Sensitivity	Yes No	Mucous Discharge	Yes No	Fluctuating Vision	Yes No
Tired Eyes	Yes No	Drooping Eyelid	Yes No	Loss of Vision	Yes No
Amblyopia (Lazy Eye)	Yes No	Redness	Yes No	Loss of Side Vision	Yes No
Burning	Yes No	Sandy or Gritty Feeling	Yes No		

GENERAL HEALTH CONDITIONS/ISSUES (please circle yes or no indicating if you have any of the following conditions)

Fever	Yes No	Respiratory (Asthma)	Yes No	Anxiety or Depression	Yes No
Weight Loss	Yes No	Gastrointestinal	Yes No	Thyroid, Diabetes	Yes No
Other Symptoms	Yes No	Kidney	Yes No	Blood/Lymph	Yes No
Ears, Nose, Throat	Yes No	Muscles, Bones, Joints	Yes No	Allergic	Yes No
Cardiovascular(high blood pressure etc.)	Yes No	Skin	Yes No	Pregnant?	Yes No
		Neurological (Multiple Sclerosis)	Yes No	Nursing?	Yes No

FAMILY HISTORY (please circle yes or no indicating if anyone in your family has or had the following conditions)

Amblyopia (Lazy Eye)	Yes No	Retinal Detachment	Yes No	High Blood Pressure	Yes No
Blindness	Yes No	Strabismus (Eye Turn)	Yes No	Kidney Disease	Yes No
Cataract(s)	Yes No	Arthritis	Yes No	Lupus	Yes No
Color Blindness	Yes No	Cancer	Yes No	Stroke	Yes No
Glaucoma	Yes No	Diabetes	Yes No	Thyroid Disease	Yes No
Macular Degeneration	Yes No	Heart Disease	Yes No	Others	Yes No

SOCIAL HISTORY

Current Occupation: _____ Years Employed:_____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ○ No How many hours/day? _____ Distance from Computer (inches)? _____

Do you drive? ○ Yes ○ No Mileage to work each way? _____

Do you have glare problems? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

Do you currently wear glasses? ○ Yes ○ No If yes, since what year? _____

Type of glasses ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Glasses Owned ☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ ○ Yes No

Do you wear sunglasses? ○ Yes ○ No Are your sunglasses your current prescription? ○ Yes ○ No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions or anti-glare tints or coatings)
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (woodworking, welding, etc.)
☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time? ○ Yes ○ No

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? _____

Do you currently wear contact lenses? ○ Yes ○ No Since what year _____

Type and brand of contact lenses _____ Today's wearing time (hrs)? _____

How many hours/day typically wear? _____ How many days/week typically wear? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SOCIAL HISTORY (additional)

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol? If yes, how much/often: ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Use tobacco? If yes, how much/often: ○ No ○ Occasional ○ ½ pack/day ○ 1 pack/day ○ 1+ pack/day

Method of Tobacco Intake: ○ Smoking ○ Chewing

Do you use Illegal Drugs: ○ Yes ○ No

Hobbies/ Interests: _____