Mattawan Family Eye Care
Medical and Vision History Information

First Name _____ MI _____ Last Name _____ Preferred Name _____ Male ☐ Female ☐

Date of Birth _____ Last 4 Digits of SSN _____ Guardian Name (if patient is a minor) and relation to patient _____

Address _____ City/State/Zip Code _____

Patient Occupation/Employer or Grade/School: _____

Hobbies: _____

	Yes	No	
Do you wish to be contacted by email?	☐	☐	Preferred email address _____
Do you wish to be contacted by text message?	☐	☐	Preferred cell phone # _____

IF YOU ARE A NEW PATIENT, how did you hear about our office?

☐ Doctor ☐ School ☐ Website ☐ Social Media ☐ Printed Ad ☐ Other _____

☐ Friend/Family: Who may we thank for referring you? _____

What is the main reason for today's Eye Health Examination? _____

When was your last eye appointment? _____

Who is your most recent eye care provider? _____

Who is your primary health care physician? _____

Eye Health History

Have you ever been diagnosed with any of the following conditions?

- Cataract ☐
- Macular Degeneration ☐
- Glaucoma ☐
- Diabetes ☐
- Diabetic Retinopathy ☐
- Eye infection/inflammation/allergy ☐
- Floaters and/or flashes of light ☐
- Iritis or Uveitis ☐
- Retina defects/degenerations ☐

Other _____

Do you have any of the following symptoms at this time?

- Redness ☐
- Burning ☐
- Itching ☐
- Tearing ☐
- Discharge ☐
- Blurred Vision ☐
- Eyestrain ☐
- Eye pain ☐
- Severe light sensitivity ☐
- Headaches ☐
- Poor night vision ☐
- Bothersome night glare ☐
- Double vision ☐
- Total loss of vision ☐

Other _____

If you are experiencing any of the symptoms above, please describe the severity (mild, moderate, severe), frequency (# of times/week) and progression (improving, worsening), etc. _____

Vision Correction

What corrective lenses do you use for far/distant vision activities? Glasses ☐ Contacts ☐ None ☐

Describe the quality of your far/distant vision activities: Acceptable ☐ May Need Improvement ☐ Blurred ☐

What corrective lenses do you use for near/reading vision activities? Glasses ☐ Contacts ☐ None ☐

Describe the quality of your near/reading vision activities: Acceptable ☐ May Need Improvement ☐ Blurred ☐

What corrective lenses do you use for computer vision activities? Glasses ☐ Contacts ☐ None ☐

Describe the quality of your computer vision activities: Acceptable ☐ May Need Improvement ☐ Blurred ☐

Please circle the most accurate response for each question. You may write any additional comments on the lines provided below each section.

Computer Demands: Do you have any of the following computer demands on your vision?

Computer use for extended periods	Yes / No
Unusual ergonomic demands	Yes / No
Must simultaneously view paper & computer	Yes / No
Use of laptop	Yes / No
Use of multiple desktop monitors	Yes / No

Vision Performance: Do you have any of these vision performance problems?

Poor reading skills	Yes / No
Inconsistent sports vision performance	Yes / No
Slowness when shifting focus	Yes / No
Difficulty with 3-D images, movies, or TV	Yes / No

How many hours per day do you spend on a computer/tablet/smartphone? _____ Hours

Additional Comments _____

_____

_____

Outdoor Demands: Please describe any special outdoor demands.

Extended night driving	Yes / No
Outdoors in direct UV exposure	Yes / No
Read in outdoor settings	Yes / No
Irritated contact lenses when outdoors	Yes / No

Eyeglass Desires: Do you have any of the following desires for your eyeglasses?

Replace uncomfortable/broken/lost glasses	Yes / No
Extra eyeglasses for special activities	Yes / No
Interest in specific fashion or brands	Yes / No
Would like thinner, lighter lenses	Yes / No
Reduction of eye strain from glare	Yes / No

Additional Comments _____

_____

_____

Purchasing Plans: Do you plan to purchase any of the following?

New eyeglasses	Yes / No
Prescription sunglasses	Yes / No
Non-prescription sunglasses	Yes / No
Computer eyeglasses	Yes / No
Reading eyeglasses	Yes / No
Sport eyeglasses	Yes / No
New supply of contact lenses	Yes / No

Interests: Are you interested in any of the following?

New contact lens fitting	Yes / No
New technology/more comfortable contacts	Yes / No
One-day use contact lenses	Yes / No
Contacts of a different replacement period	Yes / No
Vision therapy	Yes / No
Laser vision correction	Yes / No

Additional Comments _____

_____

_____

General Health History

Check the box for your present diagnoses, and circle any specific diagnoses that apply to you:

- ☐ **Constitutional** (Developmental Disability, Cancer, Fatigue Syndrome)
- ☐ **Ear, Nose, Throat** (Hearing loss, Sinusitis, Dry mouth, Laryngitis)
- ☐ **Neurological** (Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor, Stroke/CVA, Migraine)
- ☐ **Psychological** (Depression, ADD, Anxiety, Bipolar Disorder)
- ☐ **Cardiovascular** (High blood pressure, Heart Disease, Congestive Heart Failure)
- ☐ **Respiratory** (Asthma, Sleep Apnea, Emphysema, Chronic Obstruction)
- ☐ **Gastrointestinal** (Crohn's, Colitis, Ulcer, Celiac)
- ☐ **Genitourinary** (Kidney Disease, Prostate Disease, Pregnant, Nursing, Herpes, Chlamydia)
- ☐ **Musculoskeletal** (Arthritis, Fibromyalgia, Muscular Dystrophy, Osteoporosis, Gout)
- ☐ **Integumentary** (Eczema, Rosacea, Psoriasis, Herpes Simplex/Zoster)
- ☐ **Endocrine** (Diabetes, Thyroid Dysfunction, Hormonal Dysfunction)
- ☐ **Hematologic/Lymphatic** (Anemia, Ulcer, Hypercholesterolemia)
- ☐ **Allergy/Immunity** (Rheumatoid Arthritis, Lupus, Environmental Allergies)

Current medications (include eye drops, vitamins and supplements)_____

_____

Medication Allergies _____

_____

Do you drink alcohol? Yes / No If so, how much?_____
Do you smoke? Yes / No If so, how much?_____
Previous smoker? Yes/No

Family Medical History

Circle the members of your family with the following health/vision concerns:

Cancer	Dad / Mom / Brother/ Sister / Grandparent	**Cataracts**	Dad / Mom / Brother/ Sister / Grandparent
Diabetes Type 1	Dad / Mom / Brother/ Sister / Grandparent	**Macular Degeneration**	Dad / Mom / Brother/ Sister / Grandparent
Diabetes Type 2	Dad / Mom / Brother/ Sister / Grandparent	**Glaucoma**	Dad / Mom / Brother/ Sister / Grandparent
High blood pressure	Dad / Mom / Brother/ Sister / Grandparent		
Hyperthyroidism	Dad / Mom / Brother/ Sister / Grandparent		
Hypothyroidism	Dad / Mom / Brother/ Sister / Grandparent		

Other_____

_____

Please Read and Sign:

The patient's portion is due at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in the office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Mattawan Family Eye Care. I understand that my primary insurance will be billed on my behalf. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Printed Name _____ Date _____