ROSIN EYECARE

When the Decision is Vision

Rosin Eyecare Health History

First Name: ______________________________

Last Name: ______________________________

Date of Birth: ______________________________

Gender Identity: ______________________________

Race: ______________________________

Ethnicity: ______________________________

Are you interested in LASIK? ☐ Yes ☐ No

Primary Care Physician Name: ______________________

Primary Care Physician Phone #: ______________________

Primary Care Physician Hospital Affiliation: ______________

Preferred Language: ______________________

Do you currently have any of the following? *Check all that apply*

☐ Blurred Distance Vision
☐ Blurred Near Vision
☐ Trouble with Current Eyewear
☐ Tired Eyes/Eye Strain
☐ Poor Night Vision/Difficulty with Glare

☐ Floaters or Spots
☐ Flashes of light
☐ Regular Headaches
☐ Double Vision
☐ Pregnant / Nursing

☐ Dryness
☐ Sandy or gritty Feeling
☐ Watery Eyes
☐ Redness
☐ Itchy Eyes

Do you currently or have you ever had any of the following? *Check all that apply*

☐ Amblyopia ("Lazy Eye")
☐ Cataract
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal Detachment
☐ Eye Surgery
☐ Other Eye Disorders: ______________
☐ Heart Disease
☐ Hypertension
☐ High Cholesterol
☐ Cancer (Please Specify Type)
____
☐ Anemia
☐ Leukemia

☐ Loss of Appetite
☐ Dizziness
☐ Diabetes Mellitus:
  ☐ Type 1
  ☐ Type 2
☐ Thyroid Disease
☐ Other Endocrine Disorders
☐ Gastrointestinal Disorders
☐ Sexually Transmitted Disease
☐ Headaches
☐ Migraine
☐ Sinusitis
☐ HIV / AIDS
☐ Herpes Zoster (Shingles)

☐ Acne Rosacea
☐ Eczema
☐ Lupus
☐ Multiple Sclerosis
☐ Psychiatric Disorders
☐ Asthma
☐ Emphysema
☐ Other:
____
____
____
☐ Surgeries______________________________
____
____

Medications & Allergies

Are you allergic to any medications? ☐ No ☐ Yes If yes, to what?______________________________

Do you have any non-medication allergies? ☐ No ☐ Yes If yes, to what?______________________________

Please List all medications (including over the counter medicines, vitamins/supplements, and eye drops) you are taking:

____
____
____
____

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Family History (*Please check all that apply and specify relation*)

☐ Amblyopia ("Lazy Eye") ___________________________________	☐ Blindness ____
☐ Eye Surgery____	☐ Other Eye Disorders __________________________________
☐ Glaucoma____	☐ Diabetes ____
☐ Keratoconus ____	☐ Hypertension ____
☐ Macular Degeneration____________________________________	☐ High Cholesterol ______________________________________
☐ Retinal Detachment______________________________________	☐ Other ____

Social History

Do you use any cigarettes or tobacco? ☐ Never ☐ Former Smoker ☐ Current Smoker ☐ How many packs per day?______

Do you drink alcohol? ☐ No ☐ Social Drinker ☐ 1 to 2 Drinks Daily ☐ More than 2 drinks daily

Do you use other substances? ☐ Yes ☐ No

Eyewear History

Glasses

What kind of glasses do you currently own? *Check all that apply*

☐ Distance
☐ Near
☐ Computer
☐ Multifocal
☐ Backup Pair(s)
☐ Safety Glasses
☐ Sunglasses
☐ Sports Glasses
☐ Transitions
☐ Other

How many hours per day are you on a computer? _________

Contacts

What type of contact lenses do you wear?

☐ Soft Daily ☐ Soft Bi Weekly ☐ Soft Monthly ☐ Hard / Gas Permeable ☐ Other (please specify) _________________

What brand of contacts do you wear? ____

Referral

How were you referred to us?

☐ Drive/Walk by
☐ Website
☐ Insurance Company
☐ Other

Reviewed: Initials_______ Date_________ Initials_______ Date_________ Initials_______ Date_________ Initials_______ Date_________