HILL EYE ASSOCIATES

Beaver Brook Village
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VISION & HEALTH HISTORY

Patient Name ________________________________ Email ______________________________________

Date of Birth ___________________ Primary Care Physician (PCP) __________________________________

Cell Phone __________________________________ Occupation _________________________________

Address ____________________________________ Social Security Number _____ - _____ - ___________

____ Hours per day in front of a screen/computer _______

EYE HISTORY

Have you ever had any of the following eye conditions/symptoms?

Condition			Condition		
Blurred Vision	*Yes*	*No*	Tearing	*Yes*	*No*
Double Vision	*Yes*	*No*	Light Sensitivity	*Yes*	*No*
Lazy Eye/Crossed Eye	*Yes*	*No*	Injury to Eyes	*Yes*	*No*
Flashes/Floaters	*Yes*	*No*	Surgery to Eyes	*Yes*	*No*
Sandy/Gritty/Dryness	*Yes*	*No*	Macular Degeneration	*Yes*	*No*
Itchy Eyes	*Yes*	*No*	Glaucoma	*Yes*	*No*
Burning Eyes	*Yes*	*No*	Cataracts	*Yes*	*No*

MEDICAL INFORMATION

When was your last eye exam? *<1 yr* *1 yr* *2 yrs* *2-5 yrs* *5+ yrs* *Never*

Do you currently wear? *Glasses* *Contacts* *Neither*

When was your last physical exam? *<1 yr* *1 yr* *2 yrs* *2-5 yrs* *5+ yrs* *Never*

Do you have Diabetes? *Yes* *No* *If yes, how many years as a diabetic?* _____________

Type? _________________ Last A1C? _____________________

Heart Disease? *Yes* *No* High Blood Pressure? *Yes* *No* Stroke? *Yes* *No*

High Cholesterol? *Yes* *No* Other ________________________________

Current Medications/Or provide a list ____

____

____

Medication Allergies ____

____

FAMILY/SOCIAL HISTORY

Does anyone in your family have (circle if relevant): *Glaucoma* *Macular Degeneration?*

Do you smoke cigarettes (circle one)? *Yes* *No* *Former* Current packs/day ______________