



Beaver Brook Village
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VISION AND HEALTH HISTORY

Patient Name _____ **Salutation** (Mr/Mrs/Ms/etc) _____

Birthdate ___/___/_____ **Age** _____ **Sex** M / F **SS#** _____

Address _____ **City** _____ **State** _____

Cell Phone (_____) - _____ - _____ **Home Phone** (_____) - _____ - _____

Email _____ @ _____ **Race:** _____

Primary Language: _____ **Ethnicity:** Hispanic/Latino Non-Hispanic Unknown

Marital Status: _____ **Birth State:** _____

Occupation: _____ **Employer:** _____

EYE HISTORY

Have you ever had any of the following eye conditions? (circle "yes" or "no")

Glaucoma.....	Yes	No	Sandy or Gritty.....	Yes	No
Loss of Vision.....	Yes	No	Itchy eyes.....	Yes	No
Blurred Vision.....	Yes	No	Burning eyes.....	Yes	No
Distorted Vision.....	Yes	No	Tearing.....	Yes	No
Loss of Side Vision.....	Yes	No	Light Sensitivity.....	Yes	No
Double Vision.....	Yes	No	Dryness.....	Yes	No
Lazy Eye/Crossed Eye.....	Yes	No	Injury to your eyes.....	Yes	No
Flashes/Floaters.....	Yes	No	Surgery to your eyes.....	Yes	No

MEDICAL INFORMATION

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

Who is your primary care physician/pediatrician? _____

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? _____

Do you have any other health problems? Yes No

If yes, explain: _____

Current Medications: _____

Medication allergies: _____

FAMILY/SOCIAL HISTORY

Does anyone in your family have Diabetes, Glaucoma, or other eye diseases? Yes No

If yes, who? _____

Do you smoke? Yes No Former smoker Current packs/day: _____

Do you currently wear: Glasses Contacts Neither

Do you have trouble with: Daytime driving Night driving Both