hiemstra optical

Focused on You

Patient Health History

Today's Date : _____

Name : _____ Primary Doctor : _____

Date of Birth : _____ Do you wear :

Last Eye Doctor : _____ • Glasses? Yes / No

Date of Last Eye Exam : _____ • Contact Lenses? Yes / No, Hrs/Day : ____

Occupation : _____ Replacement Schedule : Daily - Monthly - Bimonthly - Other

Hobbies : _____ Are you interested in Contact Lenses? Yes / No

Visual Concerns

Distance Vision Blurry	☐ **Yes / No** ☐ **w/ Glasses?/Contacts?**	Double Vision	☐ **Yes / No** ☐
Close-Up Vision Blurry	☐ **Yes / No** ☐ **w/ Glasses?/Contacts?**	Macular Degeneration	☐ **Yes / No** ☐
Headache	☐ **Yes / No** ☐	Retinal Disease	☐ **Yes / No** ☐
Seeing Flashes	☐ **Yes / No** ☐	Glaucoma	☐ **Yes / No** ☐
Seeing Floaters	☐ **Yes / No** ☐	Cataract	☐ **Yes / No** ☐
Loss of Vision	☐ **Yes / No** ☐	Lazy Eye	☐ **Yes / No** ☐
Dry Eyes	☐ **Yes / No** ☐	Eye Injury	☐ **Yes / No** ☐

Eye Surgery ☐ **Yes / No** ☐ What type : _____

Use of Eye Drops ☐ **Yes / No** ☐ What type : _____

General Health History

Diabetes	☐ **Yes / No** ☐	Thyroid	☐ **Yes / No** ☐	HIV/AIDS	☐ **Yes / No** ☐
High Blood Pressure	☐ **Yes / No** ☐	Stroke	☐ **Yes / No** ☐	Migraines	☐ **Yes / No** ☐
Multiple Sclerosis	☐ **Yes / No** ☐	Heart Condition	☐ **Yes / No** ☐	Alcohol Use	☐ **Yes / No** ☐
Arthritis	☐ **Yes / No** ☐	Cancer	☐ **Yes / No** ☐	Tobacco Use	☐ **Yes / No** ☐
Lung Conditions	☐ **Yes / No** ☐	Shingles	☐ **Yes / No** ☐	Chemical Dependency	☐ **Yes / No** ☐
Autoimmune Disease	☐ **Yes / No** ☐			Pregnant (if applicable)	☐ **Yes / No** ☐

Other:_____

Family Vision History (Parents, Siblings, Grandparents)

Diabetes	☐ **Yes / No** ☐	Macular Degeneration	☐ **Yes / No** ☐
Glaucoma	☐ **Yes / No** ☐	Retinal Disease	☐ **Yes / No** ☐

List Medications you are currently taking:

_____

_____

List Medical Allergies:

_____

_____