Patient # _____ **Simply Optometry Patient History Form** Date ____/____/_____

Patient Name: Last: _____ First: _____

Address: _____ **Date of Birth:** _____/_____/_____ **Gender:** M F

City/State/Zip: _____,_____,_____ **SSN:** _____–_____ – _____

Primary Phone: (_____)_____ **Occupation:** _____

E-Mail: _____ **Marital Status:** _____

Preferred Contact: E-mail Mail Phone **Hobbies:** _____

Referred By: _____ **Race/Ethnicity:** _____

Language: _____

General Health History **Date of Last Physical Exam:** ____/____/_____

Seasonal Allergies	Hypertension	Heart Disease	High Cholesterol	Thyroid Disease
Digestive Problems	Urinary Disorder	Autoimmune Disorder	Skin Disorder	Blood Disorder
Arthritis	Back Pain	Neurologic Disorder	Psychiatric Disorder	Asthma

Diabetes (Date of Diagnosis): _____ Type I Type II

Surgical History (with dates): _____

Other Health Issues (Please Specify): _____

Eye and Vision History **Date of Last Eye Exam:** ____/____/_____

Glaucoma	Cataracts	Keratoconus	Lazy Eye	Macular Degeneration
Eye Injury	Eye Infection	Eye Surgery	Floaters	Retinal Detachment
Eye Allergies	Dry Eye	Color Deficiency	Pterygium	Diabetic Retinopathy

Other (Please Specify): _____

Surgical History (with dates): _____

Do you wear glasses? Yes No **Date of Prescription:** _____ **Use:** Distance Near Computer

Do you wear contacts? Yes No **Date of Prescription:** _____ **Type/Brand:** _____

Are you interested in LASIK? Yes No

Medications

_____

_____

Allergies: _____

Smoking Status: Never Smoker Former Smoker Occasional Everyday *Years Smoked:* _____

Family History

Hypertension	Relationship: _____	Glaucoma	Relationship: _____
Diabetes	Relationship: _____	Cataracts	Relationship: _____
Thyroid Disease	Relationship: _____	Macular Degeneration	Relationship: _____
Cancer	Relationship: _____	Keratoconus	Relationship: _____

Other Health Issues (Please Specify): _____

Emergency Contact: _____ **Relationship:** _____ **Phone: (____)** _____

Primary Doctor: _____ **Phone: (____)** _____

Pharmacy: _____ **Phone: (____)** _____

Vision Insurance: _____ **Health Insurance:** _____

All information disclosed on this form is strictly confidential and conforms to HIPAA regulations.