Highline Vision Center - Adult Medical History Form

Fill out your information online now to save time in the office. Clicking 'Send' will submit your form to our e-mail address. All information is kept strictly confidential. We take your privacy very seriously.

Personal Information

First Name:	Middle Initial:	Last Name:	
Preferred Name:	DOB:	Age:	
Occupation:	Height:	Weight:	
Address:			Apt #:
City:		State:	Zip:
Phone:	Cell:	E-mail:	
Date of last vision exam:		Primary Care Physician:	
Who may we thank for referring you to us?			

Vision Insurance

Vision insurance covers a routine eye exam, which is the preventative, yearly vision exam that helps maintain good eye health.

Insurance Company:	Policy #:	Group #:
Primary Insured:	Primary Insured DOB:	

Medical Insurance

Health or medical insurance covers eye exams and treatment plans only when they are necessary to treat a medical eye condition.

Insurance Company:	Policy #:	Group #:
Primary Insured:	Primary Insured DOB:	

Medical History

What would you like to address with the doctor today?		
Are you currently having vision difficulties? Yes / No	If yes, at which distance are you having difficulty? circle all that apply: Near Far Computer	
What are your symptoms, if any? (circle all that apply)	double vision eye strain itchy pain dry eye	eye turn / wandering eye floaters / flashers headaches lost of side vision red eye
Have you ever had a head injury, concussion, or whiplash?		
Workplace vision demands? (What are your daily demands at work, ie. computer, near work, driving)?		
How long are you on a computer each day?	Do you experience eye strain with computer use?	
Hobbies:		

Do you currently wear:	Glasses?	How often? Circle all that apply: full-time near only distance only computer	
Contacts?		What type?	
Contact Wearers:	Daily wear time?	Wear time today?	Contact Solution Used?

Do you currently have any of the following health problems in the following areas? Circle all that apply.

Allergy: Medications Pollen Dust Shellfish Animal Dander Molds Other:

Cardiovascular: Heart Disease Hypertension Elevated Cholesterol

Constitutional: Dizziness Weight loss/gain Cold Cough Fever

Endocrine: Diabetes Thyroid Disease

Gastrointestinal: Acid Reflux Ulcer Colitis Gall Stones

Genitourinary: Bladder Infection Kidney Stones

Head/ENT/Dental: Dry Mouth Ear Infection Headaches Sinusitis

Hematological/Lymphatic: Sickle Cell Leukemia Lymphatic Cancer Anemia

Immunologic: AIDS Herpes Simplex Herpes Zoster Mononucleosis

Integumentary (skin): Acne Rosacea Psoriasis Lupus Skin Lesions

Musculoskeletal: Arthritis Myasthenia Gravis Osteoporosis

Neurological: Bell's Palsy Multiple Sclerosis Migraine Headaches Epilepsy

Psychiatric: Alzheimer's Autism Anxiety Depression Attention Disorder

Respiratory: Asthma Bronchitis COPD Pneumonia Lung Disease Cancer

Cancer (type and date):

Please list any and all medications, vitamins, herbal supplements and eye drops that you are currently taking (if you do not know that name, please list the condition for which you are taking the medication:

List any eye surgeries and the dates:

Social History (circle all that apply): Tobacco Alcohol None

Family Medical History

Do any of your close blood relatives have any of the following (please indicate which family member)?

Cataracts:

Macular Degeneration:

Lazy Eye:

Color Blindness:

Glaucoma:

Cancer:

High Blood Pressure:

Heart Problems:

Diabetes:

Other:

Athletic Performance

Participate in Athletics? Yes / No

Which sports do you play?

Which events/ positions?

Is sports performance variable, especially with increased pressure or fatigue?

Is concentration lost during sports performance? Yes / No

Rate how important you feel vision is in competition (1 being the lowest, 10 being the highest)

1 2 3 4 5 6 7 8 9 10