BRUSH OPTICAL
MEDICAL/SOCIAL HISTORY AND REVIEW OF SYSTEMS

Patient Name________________________ Today's Date________________________

Your Eye History

Last Eye Exam__________ Last Eye Dr.______________

Do you currently wear Glasses? YES / NO

When? All of time / TV / Reading / Computer

Have you ever worn Contacts? YES / NO

Do you wear Contacts now? YES / NO

What type / brand?____________________

Are you interested in Contacts today? YES / NO

Have you ever had LASIK/PRK/RK surgery? YES / NO

Are you interested in LASIK surgery? YES / NO

Social History

Do you use a computer? YES / NO

If **yes**, how many hours / day? __________

Please list a few of your favorite hobbies:

____

Do you use tobacco? YES / NO

If **yes**, for how many years? __________

Do you drink alcohol frequently? YES / NO

If **yes**, how frequent? __________

Do you use illegal drugs? YES / NO

If **yes**, type and amount __________

Check Which Eye Conditions Apply To YOU

- ___Blurry Distance Vision
- ___Blurry Near Vision
- ___Eyestrain
- ___Double Vision
- ___Night Glare
- ___Light Sensitivity
- ___Burning/Watery Eyes
- ___Itchy Eyes
- ___Discharge from eyes
- ___Dry Eyes
- ___Eye Infection
- ___Pain or soreness
- ___Loss of vision
- ___Headaches
- ___Floaters
- ___Flashes of light
- ___Crossed/Lazy Eye
- ___Eye Injury
- ___Cataract
- ___Cataract Surgery
- ___Other Eye Surgery
- ___Glaucoma
- ___Macular Degeneration
- ___Retinal Detachment
- ___Other Retinal Disease
- ___Stye(s)
- ___Blind Spot in Vision
- ___Droopy Eyelid

FAMILY Health History

Check which conditions apply to YOUR FAMILY

(Blood relatives only: Parent/Grandparent/Sibling)

Disease/Condition	Relationship
___Blindness	______
___Cataract	______
___Crossed Eye/Lazy Eye	______
___Glaucoma	______
___Macular Degeneration	______
___Retinal Disease/Detach	______
___Cancer	______
___Diabetes	______
___Heart Disease	______
___High Blood Pressure	______
___Thyroid	______
___Arthritis	______
___Kidney Disease	______
___Other	

Please list all eye injuries and year: ______________________________

Please list all eye surgeries and year: ______________________________

Please list all major surgeries and/or hospitalizations you have had: ______________________________

____

Pharmacy Name:____________________ Pharmacy Phone #:____________________

MEDICATIONS

List any medications which you are currently taking.

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ALLERGIES

List all allergies both medical and enviromental.

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Acknowledgement of Receipt of Notice of Privacy Practices

A copy of the Notice of Privacy Practices will be provided to you upon request in the office or you can view on our website. I acknowledge that I have read and understand the Notice of Privacy Practices at Brush Optical.

______________________ ______________________ __________

Patient signature or Representative of patient **Print Name** **Date**