

Eyecare Associates

HPI

Are you experiencing any of the following?

Loss or change of vision	No	Yes
Blurry Vision	No	Yes
Injury to affected eye	No	Yes
Pain or irritation	No	Yes
Problems around eye or lid	No	Yes
Watery eyes	No	Yes
Discharge	No	Yes
Discoloration of eye	No	Yes
Flashes or floaters	No	Yes
Other	No	Yes

Your Eye History

Do you have a history of any of the following?

Cataracts	No	Yes
Glaucoma	No	Yes
Retinal Detachment	No	Yes
ANY Eye Surgery	No	Yes
Iritis/Inflammation	No	Yes
Corneal Disease	No	Yes
Eye Injury	No	Yes
Macular Degeneration	No	Yes
Diabetic Retinopathy	No	Yes
Dry Eyes	No	Yes
Eye Pain	No	Yes
Flashes or floaters	No	Yes
Halos	No	Yes
Allergies	No	Yes
Glare sensitivity	No	Yes
ANY FAMILY history of the above list?	No	Yes
Do you wear glasses?	No	Yes
Yes, how old are they?	_____	
Do you wear contacts?	No	Yes
Yes, type: Soft or Daily Wear, Extended Wear or Gas Perm		

Please circle one of the following:

Living Situation: With Family, Alone, In a Facility

Working Situation: Full time, Part time, Retired, Students - circle one: Elementary, Middle/high school, College

Patient Name: _____

Medical History

Diabetes	No	Yes: Insulin/Non-insulin
High blood pressure	No	Yes
Heart disease	No	Yes
Heart attack	No	Yes
Chest pains	No	Yes
Irregular heart beat	No	Yes
Pacemaker	No	Yes
Cholesterol Issues	No	Yes
Blood Clots	No	Yes
Epilepsy/seizures	No	Yes
Fainting	No	Yes
Stroke/TIA	No	Yes
Cancer	No	Yes
HIV/AIDS	No	Yes
Hepatitis	No	Yes
Asthma	No	Yes
Arthritis	No	Yes
Lyme disease	No	Yes
Gall bladder	No	Yes
Sickle Cell anemia	No	Yes
Ulcerative colitis	No	Yes
Emotional problems	No	Yes
Skin conditions	No	Yes
Lupus	No	Yes
Thyroid disease	No	Yes
Parkinson	No	Yes
MS	No	Yes
Kidney disease	No	Yes
Headaches	No	Yes
Bronchitis	No	Yes
Emphysema	No	Yes
Pregnant/Nursing	No	Yes
ANY FAMILY history of the above list?	No	Yes

Height: _____

Weight: _____

Social History

Do you drink alcohol? No Yes: Social or Daily
Do you smoke? No – Never smoked
Yes – every day or some days or
Former smoker

Advanced Directive

Do you have an Advanced Directive for Healthcare? No Yes

Date: _____

