

# Welcome to our office

**Dr. Kowalski, O.D.**

The information in this confidential personal history form is critical  
to the evaluation of your vision

**Patient History** Name \_\_\_\_\_  
Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
ZIP \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone(\_\_\_\_\_) \_\_\_\_\_  
Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Person Responsible for account \_\_\_\_\_ Email \_\_\_\_\_  
Vision care Insurance?  Yes  No  VSP  EYEMED  MES  \_\_\_\_\_  
Name of carrier or group \_\_\_\_\_ identification # \_\_\_\_\_  
Date of your last eye examination \_\_\_\_\_ Have you ever had vision therapy?  Yes  No  
Have you ever worn glasses?  Yes  No Do you wear glasses now?  Yes  No

**What is your main reason for coming here today?**

**Are you interested in?**  Refractive Surgery  Laser Correction  Non-Surgical

If yes:  for distance only  for near only  wear them full time  for computer monitor  sports

Do you wear contact lenses at this time?  Yes  No What type?

Have you had problems wearing contacts?  Yes  No Describe

Are you interested in trying contacts?  Yes  No

**OCCUPATION: What kind of work do you do?** \_\_\_\_\_

**What activities do you do at work:** *(Circle all that apply)* driving typing data entry  
computers program inspecting accounting writing/editing using spread-sheets loading  
deliveries sales monitor instruments.

**Do you use a computer on your job or at home? . . .**  Yes  No # hours daily \_\_\_\_\_

**Do you experience any of the following discomforts at work or at home?**

- Headaches?  Letters blur as you read?  Occasionally see double?
- Eyestrain?  Eyes red or watery?  Pulling sensation near eyes?
- Get sleepy?  Lose your place often?  Do you avoid certain tasks?
- Does it take more and more effort to see clearly as the day wears on?
- Do you avoid reading after work, but read on weekends? How long can you read? \_\_\_\_\_

How did you choose our office for your visual needs ?  Relative  Friend  Insurance List

Sign/Building  Previous Patient  Other \_\_\_\_\_

**Please fill in both sides of this form as completely as possible**

**RECREATION AND LEISURE:**

**In what recreational activities do you participate?** (Circle all that apply) read racquetball tennis  
golf baseball basketball swim camp sew play cards flying video games musical instrument

Other recreational activities \_\_\_\_\_ **What**

**are you doing to protect your eyes from ultraviolet exposure?** \_\_\_\_\_

**Do you currently wear glasses that have an anti-reflective coating?**  Yes  No

Do you often play video games?  Yes  No # of hours daily \_\_\_\_\_

**HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.**

- |                       |                               |                                 |
|-----------------------|-------------------------------|---------------------------------|
| Allergies             | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Respiratory disease   | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Cancer                | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Diabetes              | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Drug sensitive        | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Elevated cholesterol  | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Heart problem         | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| High blood pressure   | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Thyroid               | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Migraine or headaches | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Head trauma           | <input type="checkbox"/> Self |                                 |
| Lazy eye              | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Turned eye            | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Color "blind"         | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Light sensitive       | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Eyestrain             | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Dry eyes              | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Floaters/spots        | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Flashing lights       | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Retinal detachment    | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Blindness             | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Cataracts             | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Glaucoma              | <input type="checkbox"/> Self | <input type="checkbox"/> Family |

Eye surgery or injury \_\_\_\_\_

How is your general health? (circle one) Excllelent Good Fair Poor

Are you currently under a physician's care?  No  Yes

Dr.'s name? \_\_\_\_\_ Date of last physical \_\_\_\_\_

Are you regularly taking medications?  No  Yes

For what conditions? 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

**[www.datespringsoptometry.com](http://www.datespringsoptometry.com)**  
**Dr. Maciej Kowalski, O.D.**