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Thornton, CO 80602

Vista Eye Care

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Patient History and Health Information

Please take time to complete your personal data, eye and vision history, medications, review of medical systems, family healthy history, and Eye Comfort Questionnaire. This information will be used in your treatment, so please answer thoroughly, and on ***both sides***.

First Name _____ MI _____ Last Name _____ DOB (mm/dd/yyyy) _____

Date of Last Eye Exam _____ Location of Last Eye Exam _____ Primary Care Physician _____ Preferred Pharmacy _____

Occupation _____

Employer / School _____

Hobbies _____

Preferred Language _____

Race
- ☐ White
- ☐ Hispanic or Latino
- ☐ Asian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Decline to State

Ethnicity
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Decline to State

Do you wear glasses?
- ☐ Full-time
- ☐ Part-time
- ☐ I have back-up glasses

Type of glasses used?
- ☐ Distance
- ☐ Reading
- ☐ Computer / Office
- ☐ Bifocal/ Trifocal
- ☐ Progressive
- ☐ Sunglasses
- ☐ Safety ☐ Blue-Blocking

I am interested in:
- ☐ Trying Contact Lenses
- ☐ LASIK / PRK
- ☐ Cataract Surgery

Do you wear contact lenses?
- ☐ Soft Lenses
- ☐ GP / Hard Lenses
- ☐ Scleral Lenses
- ☐ Multi-focal
- ☐ Full-Time ☐ Part-Time

Brand of Soft Contact Lenses Worn _____

Contact Lens Solution Used _____

Replacement Time of Lenses _____

Hours at Computer Daily _____

Eye Diseases / Conditions _____

Eye Injuries _____

Eye Surgeries _____

Any other eye diagnoses to mention? _____

Type of Sunglasses Worn (i.e. Wrap, Transitions, Safety) _____

Previous Macular Pigment Density Score (if known) _____

Date of Last Health Exam _____

Drug Allergies _____

Current Eye Medications / Eye Drops Used (Rx and OTC) _____

Current Systemic Medications (Rx and OTC) _____

Current Vitamins / Supplements Used (systemic and eye) _____

Please check off any of the following that applies to your eye health:
- ☐ Amblyopia ☐ Itchy Eyes
- ☐ Cataracts ☐ Glaucoma
- ☐ Blurred Vision
- ☐ Eye Turn (Strabismus)
- ☐ Keratoconus
- ☐ Retinal Detachment
- ☐ Macular Degeneration
- ☐ Itchy Eyes
- ☐ I (have / have had) Punctal Plugs

Alcohol Consumption:
- ☐ Occasional ☐ Never
- ☐ Frequent

Are you Currently:
- ☐ Pregnant Due Date:_____
- ☐ Nursing

Is your Tetanus Shot Current?
- ☐ Yes ☐ No
- ☐ Don't Know

Smoking Status:
- ☐ Never Smoke
- ☐ Former Smoker
- ☐ Everyday Smoker
- ☐ Occasional Smoker

	Condition	Examples	Describe
☐	Ears, Nose, Throat	Allergies, Cough, Dry Mouth, Sinus	
☐	Cardiovascular	High BP, Heart Surgery, Vascular Disease	
☐	Respiratory	Asthma, Bronchitis, Emphysema, COPD	
☐	Genital, Kidney, Bladder	Kidney Stones, Frequent Urination, Impotence	
☐	Muscles, Bones, Joints	Arthritis, Joint Pains, Head / Neck Injury	
☐	Gastrointestinal	Diarrhea, Constipation, Reflux, Ulcer	
☐	Skin	Growths, Rash, Acne	
☐	Neurological	Headaches, Migraines, Seizures	
☐	Psychiatric	Depression, Anxiety, Insomnia	
☐	Endocrine	Thyroid / Diabetes	Last HbA1C if Diabetic:
☐	Blood / Lymph	Anemia, Cholesterol, Bleeding Problems	
☐	Allergic / Immunologic	Seasonal Allergies, Rheumatoid, M.S., Lupus, HIV, Hay Fever	

Eye Comfort Questionnaire

1. During a typical day in the past month, **how often** did your eyes feel discomfort?
   - **0** Never
   - **1** Rarely
   - **2** Sometimes
   - **3** Frequently
   - **4** Constantly

2. When your eyes felt discomfort, **how intense was this feeling of discomfort** at the end of the day, within two hours of going to bed?

Never Have It	Not at All Intense				Very Intense
0	**1**	**2**	**3**	**4**	**5**

3. During a typical day in the past month, **how often** did your eyes feel dry?
   - **0** Never
   - **1** Rarely
   - **2** Sometimes
   - **3** Frequently
   - **4** Constantly

4. When your eyes felt dry, **how intense was this feeling of dryness** at the end of the day, within two hours of going to bed?

Never Have It	Not at All Intense				Very Intense
0	**1**	**2**	**3**	**4**	**5**

5. During a typical day in the past month, **how often** did your eyes look or feel excessively watery?
   - **0** Never
   - **1** Rarely
   - **2** Sometimes
   - **3** Frequently
   - **4** Constantly

Please check off any of the following that applies to your family medical history:

- ☐ Adopted: History Unknown
- ☐ Blindness
- ☐ Cataracts
- ☐ Diabetes
- ☐ Eye Turn (Strabismus)
- ☐ Amblyopia (Lazy Eye)
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Macular Degeneration
- ☐ Other Disease(s): _____