SJ Vision, P.A. Patient Information

Patient History					
Name:			Age:	Today's Date	
If minor, guardian name:	Date of Birth:			Sex (Male or Female)	
Address:		City:		State:	Zip:
Home Phone:	Cell Phone:			E mail:	
Occupation:	Employer or School:			Work Phone:	

General Medical History	
Primary Care Physician Name:	Date of Last Physical:
Please list all Medications you are currently taking (in the lines below):	
Please list any allergies to medications:	
Do you currently drink? ☐ Yes ☐ No	Do you currently smoke? ☐ Yes ☐ No
Are you currently pregnant? ☐ Yes ☐No	Are you currently breastfeeding? ☐ Yes ☐No

Eye Health History	
Date of last eye exam:	Dr.'s name:
Have you ever had eye surgery or injury? ☐ Yes ☐No If yes, please explain:	

Have you ever been diagnosed with any of the following conditions?

Condition	**NO**	**YES**	**Condition**	**NO**	**YES**
Cataract			Redness		
Macular Degeneration			Burning		
Glaucoma			Itching		
Diabetes			Tearing		
Diabetic Retinopathy			Discharge		
Dry Eye					
Eye infection, inflammation or allergy					
Floaters and/or flashes					
Iritis or Uveitis					
Retinal defects or degenerations					

Family History

Please indicate their relation to YOU in the space provided. (Father, Mother, Brother, Sister, Son, or Daughter)

Cancer		Cataracts	
Diabetes Type I		Macular Degeneration	
Diabetes Type II		Glaucoma	
Hypertension		Retinal Detachment	
Hyperthyroidism		**Please turn page over to finish**	
Hypothyroidism			

Review of System			
Please circle all that apply to you:			
General	**Respiratory**	**Muscular/Skeletal**	**Hematology/Lymph**
Cancer _____	Cigarette Smoker	Osteoarthritis	Anemia
	Asthma	Arthritis	High Cholesterol
Neurology	Bronchitis	Fibromyalgia	
Multiple Sclerosis	Emphysema	Osteoporosis	**Allergy/Immunology**
Epilepsy	COPD		Rheumatoid Arthritis
Cerebral Palsy	Sleep Apnea	**Skin/Integument**	Lupus
Tumors_____		Psoriasis	Sjogren's Syndrome
Migraines	**Gastrointestinal**	Rosacea	
Autism Spectrum Disorder	Chrohn's	Herpes Simplex/Cold Sores	
	Colitis	Herpes Zoster/Shingles	
Cardiovascular	Ulcer		
Hypertension		**Endocrine**	
Stroke/CVA	**GYN/Urinary**	Diabetes: Type 1 Type 2	
Heart Disease	Kidney Disease	Thyroid Dysfunction	
Vascular Disease	Prostate Disease		
Congestive Heart Failure	STD		
	Chlamydia		

Authorization to Discuss Medical Information and Optical Orders

Please indicate who, if anyone, we may speak with regarding your medical information and/or optical orders.

☐ **No one. Please discuss my medical information and optical orders with me.**

☐ **I authorize SJ Vision Eyecare to discuss my medical information and/or optical orders with the following person(s):**

Name: _____

Relationship: _____

Phone: _____

Signature: _____ Date:_____