HILL VISION CENTER

Denise Hill, O.D.

Patient Name___________________________________

Reason for Today's Visit________________ Family Physician______________

Last Eye Exam ________

Do you wear glasses? Y/N Do you wear contacts? Y/N

Medications Currently Taking____

Any Drug Allergies? Y/N if YES, please explain _________________________

Are you Currently Experiencing: Circle Which Applies

Blurry Near Vision - with/without glasses Itchy Eyes Double Vision
Blurry Distance Vision - with/without glasses Watery Eyes Eye Strain
Discharge Headaches Dry Eyes Other:____________________

Eye History: Circle Which Applies

Eye Injury Eye Surgery Lazy Eye Glaucoma
Cataracts Macular Degeneration Diabetic Retinopathy Other: _______________

Medical History: Circle Which Applies

Diabetes Anxiety Allergies Hypertension Stroke
Arthritis High Cholesterol Asthma Multiple Sclerosis Thyroid Problems
Cancer Urinary Disorders STD Blood Transfusion

Family Eye History: Check Which Applies

□ Eye Surgery: Who________________________
□ Lazy Eye: Who __________________________
□ Glaucoma: Who __________________________
□ Macular Degeneration: Who___________________________
□ Diabetic Retinopathy: Who_____________________________
□ Other: Who______________________________________

Family Medical History: Circle Which Applies

Diabetes Hypertension Stroke Cancer Urinary Disorders
Arthritis High Cholesterol Asthma Multiple Sclerosis Thyroid Problems

Social History: Check Which Applies

□ Tobacco Use If Checked, how often:_____________________________
□ Alcohol Use If Checked, how often:_____________________________
□ Narcotics Use If Checked, how often:_____________________________