Covina Hills
Optometric Group

Dr. D.H. Duncan, Dr. Perry Hom,
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Please complete this ***Health History Form*** so we may better serve you. Thank you.

Name: _____ Today's date: _____

Name you preferred to be called:_____ Birth date: _____

Date of last Physical Exam: _____ Date of last Eye Exam: _____

REASON FOR VISIT What is the **MAIN REASON** for your visit today?

_____

SPECTACLE / CONTACT LENSES

Are you planning on getting new glasses? ☐ **YES** ☐ **NO**

How often do you wear glasses? ☐ Never ☐ Full-Time ☐ Part Time ☐ Distance only ☐ Reading only

Do you presently wear contact lenses? ☐ **NO** ☐ Full-Time ☐ Part Time

Would you like to see if you are a good candidate for the latest contact lens designs? ☐ **YES** ☐ **NO**

Would you like to discuss laser refractive surgery (LASIK) options today? ☐ **YES** ☐ **NO**

VISION NEEDS

What type of work you do? _____

What specific job related vision needs should we know about? _____

How much time do you spend on the computer? Work: _____ Hours/Day Home: _____ Hours/Day

Check any of the following symptoms that you experience while using your computer:

☐ Tired eyes ☐ Dry eyes ☐ Headaches ☐ Burning eyes

☐ Blurred vision ☐ Double Vision ☐ Red eyes ☐ Stinging eyes

Do you use special computer glasses? ☐ **YES** ☐ **NO**

Are you interested in designated glasses to make computer work easier? ☐ **YES** ☐ **NO**

SPORTS AND LEISURE What sports, recreational activities, or hobbies do you participate in?

_____

EYE / VISION PROBLEMS **Check all that apply.** ☐ **NO** Eye or Vision problems to report.

☐ Blurred Vision ☐ Eyelid: Lump/Bump ☐ Glare ☐ Eye Fatigue

☐ Burning Eyes ☐ Eyelid: Puffy/Swollen ☐ Halos ☐ Eye Pain

☐ Double Vision ☐ Recent flashes of light ☐ Headache ☐ Redness

☐ Dry Eye ☐ Recent Floaters ☐ Itchy Eyes ☐ Sandy/Gritty Feeling

☐ Eyelid: Crusty / Sticky ☐ Foreign Body Sensation ☐ Light Sensitivity ☐ Watery Eyes

Any other eye/vision problems not listed above? _____

MEDICAL HISTORY ☐ **NO** Medical History to report.

AIDS/ HIV Positive	☐	Me		Diabetes	☐	Me	☐	Family	Multiple sclerosis	☐	Me	☐	Family
Allergic disorders	☐	Me	☐	Family	Head trauma	☐	Me			Pregnant:	☐	No	Yes ____ Month
Arthritis	☐	Me	☐	Family	Heart disease	☐	Me	☐	Family	Respiratory disorder	☐	Me	☐	Family
Cancer	☐	Me	☐	Family	Hypertension	☐	Me	☐	Family	Stroke	☐	Me	☐	Family
Cholesterol, high	☐	Me	☐	Family	Migraines	☐	Me	☐	Family	Thyroid disease	☐	Me	☐	Family

Any other health problems?_____

SURGICAL HISTORY List any major injuries or surgeries you have had.

_____

EYE HISTORY ☐ **NO** Eye History to report.

Amblyopia (lazy eye)	☐	Me	☐	Family	Macular Degeneration	☐	Me	☐	Family
Blindness	☐	Me	☐	Family	Retinal Detachment	☐	Me	☐	Family
Cataracts	☐	Me	☐	Family	Strabismus (eye turn)	☐	Me	☐	Family
Color Deficiency	☐	Me	☐	Family	Glaucoma	☐	Me	☐	Family

Any other eye/vision problems? _____

EYE SURGERY/ INJURY List which eye, type of surgery or injury, and date.

_____

EYE MEDICATIONS or EYE DROPS (Including over the counter)

_____

MEDICATIONS ☐ **NO** Medications or Supplements Taken

Please list all current medications and supplements. (Including oral contraceptives, aspirin, and over the counter)

MEDICATION ALLERGY & EFFECTS ☐ **NO** Known Medication Allergies.

SOCIAL HISTORY ***Information strictly confidential.*** ☐ I would like to discuss this privately with my doctor.

☐ Tobacco use ☐ Alcohol use ☐ Narcotic use ☐ Sexually transmitted diseases

Other._____

Signature_____ Date: _____