HD Optical Express

Dr. Daniel N. Nash, OD

Patient Health History

Name_____DOB_____Age_____Today's Date_____

Occupation (School)_____(Grade)_____

Last Eye Exam_____Eye Doctor_____

Last Physical_____Primary Care Physician_____

Primary Reason For Today's Visit_____

Do you wear contact lenses? Y N Do you wear glasses? Y N

Review of Systems: Do you have a history of any of the following?

Diabetes	Y N	Cancer	Y N	Migraines, Headaches	Y N
Thyroid Disease	Y N	Multiple Sclerosis	Y N	Lupus	Y N
High Blood Pressure	Y N	Epilepsy, Seizures	Y N	Arthritis	Y N
High Cholesterol	Y N	Hepatitis	Y N	Blocked Arteries, Stroke	Y N
Congestive Heart Failure	Y N	Coronary Heart Disease	Y N	Drug, Alcohol Addiction	Y N
Irregular Heart Beat	Y N	Blood Disorder (Anemia, Sickle Cell, etc.)	Y N	Psychological, Depression	Y N
Asthma, Emphysema	Y N	Sinus Issues	Y N	Traumatic Brain Injury	Y N

Other (Please List)_____

Please List Major Surgeries (including eye)_____

Please List Current Medications_____

_____

Medication Allergies_____

Family History: Does anyone <u>in your family</u> have the following?

Glaucoma	Y N	Arthritis	Y N	High Blood Pressure	Y N
Cataracts	Y N	Cancer	Y N	Stroke	Y N
Macular Disease	Y N	Diabetes	Y N	Kidney Disease	Y N
Blindness	Y N	Heart Disease	Y N	Thyroid Disease	Y N

Social History:

Do you smoke? Y N Do you drink alcohol? Y N Drinks Per Week: _____ Are you pregnant? Y N

Eye History: Please circle any that apply to your eyes

Disease/Injury	Mattering	Pain	Double Vision
Itching	Watering	Floaters	Burning
Dryness	Blurred Vision	Flashes	Lazy Eye

□ **I have read and understand the importance of dilation: Please choose one**

□ I accept dilation today □ I accept dilation but will reschedule □ I decline dilation

Authorization for Treatment Signature_____