Timothy S. Jarvi, MD
Board Certified Ophthalmologist

Patient History

Debra L. Denton, OD
Optometrist

The information in this personal history form is critical to the evaluation of your vision. Please fill out <u>both sides</u> of this form as completely as possible. Thank you.

Name_____DOB_____Age____Sex____Date_____

Address_____

City_____State_____Zip_____

Home Phone_____Work or Cell Phone_____

Spouse_____

Parent/Guardian Name_____Phone_____

Who may we thank for referring you to our office?_____

❑ Other (Yellow pages,etc.)_____

Family Physician _____

This is your opportunity to tell us about your vision.

Does your vision restrict you from doing activities you enjoy? ◯ Yes ◯ No

Explain:_____

Are you interested in? ☐ Refractive Surgery ☐ Laser Correction ☐ Glasses/Contact Lenses
☐ Botox ☐ Eye Lid Surgery ☐ Permanent Makeup

Have you ever worn glasses? ◯ Yes ◯ No

Do you wear glasses now? ◯ Yes ◯ No If yes: ☐ for distance only ☐ for near only ☐ wear them full time

Do you have problems with your glasses or contacts? ◯ Yes ◯ No

If yes, describe:_____

Have you ever worn contacts? ◯ Yes ◯ No

Do you wear contact lenses now? ◯ Yes ◯ No If yes: ☐ Everyday ☐ At least weekly ☐ Rarely

Do you take any drops or eye medications? If so, please list:_____

Do you have allergies to any medications?_____

_____

Please list all the medications you take including vitamins, over-the-counter medications and herbs:

_____

_____

_____

_____

Your Past/Present Eye History

Do you have or have you had any of the following?

Diabetic Eye Disease	◯Yes ◯No
Glaucoma	◯Yes ◯No
Macular Degeneration	◯Yes ◯No
Eye Surgery	◯Yes ◯No
Crossed Eye or Lazy Eye	◯Yes ◯No
Cataracts	◯Yes ◯No
Eye Injury	◯Yes ◯No
Allergy/Dry Eye	◯Yes ◯No

Other:_____

Your Family Medical History

Have your blood relatives—parents, brothers, sisters and/or grandparents ever been affected by any of the following?

Diabetes	◯Yes ◯No
Glaucoma	◯Yes ◯No
Macular Degeneration	◯Yes ◯No
Retinal Detachment	◯Yes ◯No
Crossed Eye or Lazy Eye	◯Yes ◯No
Blindness	◯Yes ◯No

Other:_____

_____

General Health Review

Do you have or have you had any of the following?

Recent, unexplained weight loss/gain	◯Yes ◯No
Past Surgeries	◯Yes ◯No
Tumor or Cancer	◯Yes ◯No
Ear, Nose, Mouth or Throat Problems	◯Yes ◯No
High Blood Pressure	◯Yes ◯No
Stroke	◯Yes ◯No
Heart Problems	◯Yes ◯No
Breathing Problems	◯Yes ◯No
Asthma	◯Yes ◯No
TB (tuberculosis)	◯Yes ◯No
Stomach or Intestinal Problems	◯Yes ◯No
Hepatitis, Jaundice or Liver Problems	◯Yes ◯No
Genital/Urinary Problems	◯Yes ◯No
Kidney Problems	◯Yes ◯No
Arthritis/Bone or Joint Problems	◯Yes ◯No
Dermatological Problems/Skin Cancer	◯Yes ◯No
Thyroid Disease	◯Yes ◯No
Diabetes	◯Yes ◯No
Seizures	◯Yes ◯No
Head Injury	◯Yes ◯No
Multiple Sclerosis	◯Yes ◯No
Bleeding/Clotting Disorders	◯Yes ◯No
Anemia	◯Yes ◯No
Depression/Anxiety/Insomnia	◯Yes ◯No
Mental Illness	◯Yes ◯No

Social History

Marital Status	◯M ◯S ◯D ◯W
Drink alcohol?	◯Yes ◯No ____Drinks per wk.
Caffeinated beverages?	◯Yes ◯No_____cups per day
Do you smoke?	◯Yes ◯No

Occupation/Hobbies

What kind of work do you do?_____

Do you use a computer daily? ◯Yes ◯No

Recreational Activities:_____

_____

What type of eye protection do you use for your recreation/sport?_____

MEDICARE PATIENTS

• Please be advised that Medicare does not pay for any routine services such as refractions (prescriptions for new glasses) or routine eye exams for non-medical reasons. If you would like a refraction for new glasses the fee is $25.00 on the day of service. Please inform our staff if you would like this service.

Thank you.

Signature_____ Date_____