Hellerstein & Brenner
Vision Center, P.C.

Eye & Health History

Date ______________ Email ______________________________

Name ____ Sex: M F Date of Birth ______________

Address ______________________________ City ________________ State ______ Zip ________

Responsible Party/Parents ____________________ Spouse ____________ Soc. Sec. # ____________

Phone (H) ______________ (W) ______________ Occupation ______________ Employer ______________

Hobbies (computer, sports) ______________________________ Referred By ____________________

Reason for visit ____

Other family members seen in this office ____

Ocular History

Date of last eye examination ______________________

By Whom: ________________

	Yes	No	
Do you wear Glasses	☐	☐	________
For ☐ Distance ☐ Near ☐ Other Date Prescribed			________
Contact Lenses	☐	☐	________
Have you had vision therapy?	☐	☐	________

Do you experience any of the following?

	Yes	No	
Blurred vision	☐	☐	________
Double vision (vert., horiz., diag.)	☐	☐	________
Eye strain or fatigue	☐	☐	________
Headache	☐	☐	________
Eye pain	☐	☐	________
Burn, itch, tear	☐	☐	________
Lazy/wandering eye (left or right)	☐	☐	________
Flashes of light	☐	☐	________
Light sensitivity	☐	☐	________
Loss of field of vision/restricted field	☐	☐	________
Objects move	☐	☐	________
Difficulty tracking an object	☐	☐	________
Squinting	☐	☐	________
Frequent blinking	☐	☐	________
Redness	☐	☐	________
Floaters	☐	☐	________
Covers or closes an eye (left or right)	☐	☐	________
Rubs eye	☐	☐	________
Dryness	☐	☐	________
Watery eyes	☐	☐	________
Uncomfortable or inefficient reading	☐	☐	________

Medical History

Last Medical Exam ______________________________

By Whom ______________________________

General Health: Excellent Good Fair Poor

Do you presently have problems in the following areas?

	Yes	No	
Allergies, immune system	☐	☐	________
Sinus, ears, nose	☐	☐	________
Respiratory (lungs, breathing, TB)	☐	☐	________
Cardiovascular (heart, blood pressure)	☐	☐	________
Stomach, colon	☐	☐	________
Neurological (seizure)	☐	☐	________
Bones, joints, arthritis, muscles	☐	☐	________
Hepatitis	☐	☐	________
Endocrine (diabetes, thyroid)	☐	☐	________
Skin	☐	☐	________
Blood	☐	☐	________
Behavioral, depression	☐	☐	________
Are you pregnant?	☐	☐	________
History of stroke or head injury	☐	☐	________
Dizziness/Vertigo	☐	☐	________
Poor coordination	☐	☐	________
Difficulty in attention and concentration	☐	☐	________
Memory problems	☐	☐	________
HIV/AIDS	☐	☐	________

Do you have a history of any of the following?

	Yes	No	
Brain injury	☐	☐	________
Ear infections	☐	☐	________
Eye surgery	☐	☐	________
Eye injury	☐	☐	________
Eye disease	☐	☐	________
Cataracts	☐	☐	________
Glaucoma	☐	☐	________
Do you smoke?	☐	☐	________
Do you drink alcohol?	☐	☐	________

Please list all medications you are currently taking and why

____

____

Please list all allergies (incl. drugs) ____________________

____

Family History

Does anyone in your family have problems in the following areas?

	Yes	No	
Cataracts	☐	☐	________
Glaucoma	☐	☐	________
Macular Degeneration	☐	☐	________
Lazy/wandering eye	☐	☐	________
Retinal problems	☐	☐	________
Blindness	☐	☐	________
Diabetes	☐	☐	________
High blood pressure	☐	☐	________
Cardiovascular disease	☐	☐	________
Neurological disease	☐	☐	________
Arthritis	☐	☐	________