DR. JENNIFER L.H. MURPHY
DOCTOR OF OPTOMETRY

PATIENT HEALTH HISTORY

This information will help us provide you with better care and will be kept confidential.

Name:____ Date:_____________________________

Address:_______________________________________ City:_______________ State:_____ Zip:________

Date of Birth:______________ Home phone:___________________ Work phone:_________________

Occupation:__________________________ Email address:_______________________________________

Are you covered by vision insurance? Yes or Self Pay

PLEASE FILL OUT THIS SECTION IF YOU ARE COVERED BY VISION INSURANCE

Name of insurance company that provides your vision benefits___________________________________

Name of person that is the PRIMARY cardholder for the insurance_______________________________

Member ID# and Social Security # of PRIMARY cardholder____________________________________

Date of birth for PRIMARY cardholder____

Employer of PRIMARY cardholder____

What is the main reason for your visit today?____

Do you currently wear glasses? Yes No Do you currently wear contact lenses? Yes No
Have you ever worn contacts? Yes No Are you interested in trying contacts? Yes No

When was your last eye exam?___________________ Location of last eye exam___________________

How many hours per day do you spend on the computer?____

Please list any hobbies that you have____

CONTACT LENS HISTORY

What brand of contacts do you wear?______________ How often do you replace them?_____________

What solutions do you use to clean them?_________ How many hours/day do you wear them?_______

Do you sleep in your contact lenses? Yes No If so, how often?_____________________________

Rate the following:					
	Overall lens comfort:	Excellent	Good	Fair	Poor
	Distance vision:	Excellent	Good	Fair	Poor
	Near vision:	Excellent	Good	Fair	Poor

PLEASE TURN OVER AND COMPLETE OTHER SIDE. THANK YOU!

YOUR MEDICAL HISTORY

ENDOCRINE

Yes	No	
□	□	Diabetes
□	□	Thyroid disease
□	□	Graves' disease

RESPIRATORY

Yes	No	
□	□	Chronic bronchitis
□	□	Asthma
□	□	Ear/Nose/Throat
□	□	Sinus problems

NEUROLOGICAL

Yes	No	
□	□	Seizures
□	□	Migraines/Headaches
□	□	Multiple sclerosis
□	□	Bad fall/Head trauma

SKIN

Yes	No	
□	□	Eczema
□	□	Acne Rosacea
□	□	Skin Cancer

MUSCULOSKELETAL

Yes	No	
□	□	Arthritis
□	□	Muscle/joint pain
□	□	Fibromyalgia

GASTROINTESTINAL & GENITOURINARY

Yes	No	
□	□	Stomach problems
□	□	Genital problems
□	□	Kidney problems
□	□	Bladder problems

CARDIOVASCULAR

Yes	No	
□	□	High Blood Pressure
□	□	Stroke
□	□	Heart disease
□	□	Anemia
□	□	Arrhythmia
□	□	High Cholesterol

OTHER MAJOR ILLNESSES

Yes	No	
□	□	Cancer
□	□	Lupus
□	□	HIV/AIDS
□	□	Hepatitis

PSYCHIATRIC

Yes	No	
□	□	Depression/Anxiety/Bipolar

Any medical problems not listed above?____

Have you ever had an eye disease, surgery or injury?__________________________________

Have you had surgery to correct your vision? Yes No Are you interested? Yes No

Please list any medications you are taking ____

____

Please list any allergies you have ____

YOUR FAMILY HISTORY

Please list siblings, parents, and/or grandparents diagnosed with any of the following:

Glaucoma________________________ Diabetes_____________________________

Macular Degeneration_______________ High Blood Pressure______________________

Corneal Disease____________________ Migraines____________________________

Retinal Detachment _________________ Thyroid problems_______________________

Sjogren's Syndrome/Dry Eye __________ Heart problems_________________________

Other Eye Disorders ________________ Other major health problems________________

I acknowledge that I have read and accept the posted notice of Privacy Practices for this office.

Patient signature__________________________ Doctor signature_________________________

Guardian's signature________________________ Today's Date____________________________
(If patient is under 18)