Welcome to

20/20 EYECARE OF UTAH

Patient Name Date
Address City State Zip
Cell Phone Work Phone Home Phone/Other
Email Address How did you hear about our office?
Gender M F Birthdate Social Security#
Patient Employer or School Patient Occupation or Grade
Person responsible for payment Relationship to patient

*If you are enrolled in Vision Service Plan, please list VSP as the Primary Insurance Company, and your Medical Insurance as Secondary.

Primary Insurance Company Insured's Name
Insured's Social Security# or ID# Insured's Birthdate
Secondary Insurance Company Insured's Name
Insured's Social Security# or ID# Insured's Birthdate

Health History Questionnaire

Reason for your visit today (ie: new glasses/contact lenses, dry eye/sandy/burning/tired feeling-red eye, flashes/floaters, eye pain or discharge, etc.)

Please list any visual needs relating to your occupation, recreation, or hobbies

Do you currently wear glasses? NO Distance Only Reading Only Computer Full Time

Do you currently wear contact lenses? NO YES Brand: Power: R L

PERSONAL OCULAR HISTORY: Injuries, surgeries, and/or infections

PERSONAL MEDICAL HISTORY: Injuries, surgeries, and/or hospitalizations

OCULAR MEDICATIONS: (including over-the-counter)

SYSTEMIC MEDICATIONS: (including over-the-counter)

SOCIAL HISTORY: Use of alcohol, tobacco, or illegal drugs? NO YES Type/Quantity/Frequency

(please fill out back)

PERSONAL REVIEW OF SYSTEMS

CARDIOVASCULAR
None Heart Disease High Blood Pressure High Cholesterol Other________________________

CONSTITUTIONAL
None Anemia Excessive Hunger/Thirst/Urination Fever Other________________________

ENDOCRINE
None Diabetes Gout Hyperthyroid Hypothyroid Other________________________

GASTROINTESTINAL
None Constipation Diarrhea Stomach Ulcer Other________________________

GENITOURINARY
None Bladder/Kidney Infection Menopause STD Other________________________

HEMATOLOGIC/LYMPHATIC
None Bleeding Disorder Sickle Cell Disease Other________________________

IMMUNOLOGIC
None AIDS/HIV CMV Herpes Zoster (shingles) Other________________________

INTEGUMENTARY
None Rosacea Skin Cancer Stevens-Johnson Syndrome Other________________________

MUSCULOSKELETAL
None Arthritis Myasthenia Gravis Osteoporosis Other________________________

NEUROLOGICAL
None Headaches Multiple Sclerosis Seizures Other________________________

PSYCHRIATRIC
None Alzheimer's Anxiety Depression Other________________________

RESPIRATORY
None Asthma Chronic Bronchitis Emphysema Other________________________

SYSTEMIC **FAMILY** HISTORY:

Arthritis	NO	YES	Relationship to you
Cancer	NO	YES	Relationship to you
Diabetes	NO	YES	Relationship to you
Heart Disease	NO	YES	Relationship to you
High Blood Pressure	NO	YES	Relationship to you
High Cholesterol	NO	YES	Relationship to you
Thyroid Disease	NO	YES	Relationship to you
Other			Relationship to you

OCULAR **FAMILY** HISTORY:

Blindness	NO	YES	Relationship to you
Cataracts	NO	YES	Relationship to you
Glaucoma	NO	YES	Relationship to you
Lazy Eye	NO	YES	Relationship to you
Macular Degeneration	NO	YES	Relationship to you
Retinal Disease	NO	YES	Relationship to you
Other			Relationship to you

-- Office Use Only --

The American Optometric Association recommends an annual eye examination. Would you like us to remind you in one year about having an annual eye exam?

YES NO _____
Initials

P.D.: R: ___ L: ___ Binocular: ____
Seg. Height: _____mm.
Frame Detail: Model: __________
Color: ___________
Size: ____________