PULLMAN VISION SOURCE®

JAMES P. DEVLEMING, O.D. JENNA DEWALD, O.D.

HEALTH HISTORY

Name: _____

Today's date: _____

MEDICATIONS & SURGICAL HISTORY

Do you have any allergies to medications? ☐ No ☐ Yes: _____

Do you have environmental allergies? ☐ No ☐ Yes: _____

List all medications you currently take, including oral contraceptives, over the counter medications and home remedies: _____

_____

List any major injuries, surgeries (including eye-related) or hospitalizations you have had: _____

_____

HEALTH HISTORY

Do you now or have you ever experienced problems in the following areas? Check all that apply.

Integumentary			**Lymphatic/Hematological**			**Gastrointestinal**		
Eczema	☐ Yes	☐ No	Bleeding problems	☐ Yes	☐ No	Crohn's	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No				Colitis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	**Respiratory**			Ulcer	☐ Yes	☐ No
			Asthma	☐ Yes	☐ No	Digestive	☐ Yes	☐ No
Neurological			Chronic bronchitis	☐ Yes	☐ No			
Multiple sclerosis	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	**Genitourinary**		
Cancer	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Genitals/Kidney/Bladder	☐ Yes	☐ No
Endocrine			**Vascular/Cardiovascular**			**Psychiatric**		
Type 1 diabetes	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Type 2 diabetes	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No	Panic disorder	☐ Yes	☐ No
Thyroid dysfunction	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Schizophrenia	☐ Yes	☐ No
Hormonal dysfunction	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No			

Do you now or have you experienced problems in the following areas within the past six months? Check all that apply.

Ear/Nose/Throat			**Neurological**			**Constitutional**		
Allergies/hay fever	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Fever	☐ Yes	☐ No
Sinus congestion	☐ Yes	☐ No	Migraines	☐ Yes	☐ No	Weight loss/gain	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No	Seizures	☐ Yes	☐ No	Pregnant/nursing	☐ Yes	☐ No
Dry throat/mouth	☐ Yes	☐ No						

Please check the eye symptoms you have experienced within the past six months.

Floaters	☐ Yes	☐ No	Pain or soreness	☐ Yes	☐ No	Sties Chalazion	☐ Yes	☐ No
Double vision	☐ Yes	☐ No	Sandy or gritty feeling	☐ Yes	☐ No	Foreign body sensation	☐ Yes	☐ No
Flashes	☐ Yes	☐ No	Tearing/watery eyes	☐ Yes	☐ No	Fluctuating visual activity	☐ Yes	☐ No
Dry eye sensation	☐ Yes	☐ No	Mucous discharge	☐ Yes	☐ No	Tired eyes	☐ Yes	☐ No
Burning	☐ Yes	☐ No	Redness	☐ Yes	☐ No	Frequent headaches	☐ Yes	☐ No
Itching	☐ Yes	☐ No	Chronic infection	☐ Yes	☐ No	Light sensitivity	☐ Yes	☐ No

— PLEASE CONTINUE FILLING OUT ON THE BACK OF THIS PAGE —

SOCIAL HISTORY

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No

If yes, please describe _____

Do you smoke? ☐ Yes ☐ No Packs per day: _____ If former smoker, how long ago did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, amount: _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, type/amount/for how long? _____

Have you ever been exposed to or infected with HIV? ☐ Yes ☐ No Any other sexually transmitted diseases? ☐ Yes ☐ No

---

HOBBIES AND RECREATION

Please select all that most accurately apply to you:

- ☐ Boating/fishing
- ☐ Gardening
- ☐ Photography
- ☐ Sewing
- ☐ Card playing
- ☐ Golf
- ☐ Racquetball/handball
- ☐ Flying
- ☐ Swimming/scuba diving
- ☐ Arts and crafts
- ☐ Hunting
- ☐ Skiing
- ☐ Music
- ☐ Reading
- ☐ Fashion
- ☐ Detailed fine work
- ☐ Video games
- ☐ TV binges
- ☐ Computer activity
- ☐ Extreme sports

How many hours a day do you spend in front of a computer?

☐ I don't use a computer ☐ < 2 hours ☐ 2 – 4 hours ☐ 4 – 6 hours ☐ 6 – 8 hours ☐ 8 – 10 hours ☐ > 10 hours

How many hours a day do you spend looking at your smart phone?

☐ I don't use a smartphone ☐ < 2 hours ☐ 2 – 4 hours ☐ 4 – 6 hours ☐ 6 – 8 hours ☐ 8 – 10 hours ☐ > 10 hours

---

CURRENT VISION CORRECTION

Do you wear glasses? ☐ Yes ☐ No Do you wear contact lenses? ☐ Yes ☐ No

Type of contacts: ☐ Rigid ☐ Soft ☐ Extended wear ☐ Other: _____ Are they comfortable? ☐ Yes ☐ No

How often do you replace your contacts? ☐ Daily ☐ 1 – 2 weeks ☐ Monthly ☐ Quarterly ☐ Yearly ☐ Other _____

What brand of contacts do you wear? _____
