Lens N Specs
Patient Health History Evaluation Form

Date: _____

Patient Information

- **Full Name: _____**
- **Date of Birth: _____**
- **Address: _____**
- **Phone Number: _____**
- **Email Address: _____**

Emergency Contact Information

- **Name: _____**
- **Relationship: _____**
- **Phone Number: _____**

Vision and Eye Health History

1. **What is the reason for your visit today?** (Please check all that apply)
   - Routine eye exam
   - New glasses/contact lenses
   - Eye problem or injury
   - Other: _____
2. **Do you currently wear glasses?**
   - Yes
   - No
3. **Do you currently wear contact lenses?**
   - Yes
   - No
4. **Are you interested in trying contact lenses?**
   - Yes
   - No
5. **Do you have any of the following eye conditions?** (Please check all that apply)
   - Blurry vision Eye strain Dry eyes
   - Redness Itching Double vision
   - Floaters or flashes
   - Other: _____
6. **Have you ever had any eye surgeries or treatments?**
   - Yes (please specify): _____
   - No
7. **Family history of eye diseases (e.g., glaucoma, cataracts, macular degeneration)?**
   - Yes (please specify): _____
   - No

General Medical History

1. **Do you have any allergies?**
   - Yes (please specify): _____
   - No
2. **Please list any medications you are currently taking (including eye medications):**
   - _____
   - _____

- _____

3. **Are you currently pregnant or breastfeeding?**
    - Pregnant
    - Breastfeeding
    - Neither
4. **Do you have any chronic medical conditions?** (Please check all that apply)
    - Diabetes
    - High blood pressure
    - Heart disease
    - Asthma
    - Arthritis
    - Other: _____
5. **Have you had any surgeries or hospitalizations in the past five years?**
    - Yes (please specify): _____
    - No
6. **Family medical history (e.g., diabetes, heart disease)?**
    - Yes (please specify): _____
    - No

Lifestyle and Habits

1. **Do you smoke?**
    - Yes
    - No
2. **Do you consume alcohol?**
    - Yes
    - No
3. **How many hours do you spend on screens daily?**
    - Less than 2 hours
    - 2-4 hours
    - 4-6 hours
    - More than 6 hours

Additional Information

- **Please provide any additional information or concerns you would like to discuss with the optometrist:**
    - _____
    - _____

Signature

I certify that the above information is accurate to the best of my knowledge.

- **Patient Signature: _____**
- **Date: _____**