

VISUAL LIFESTYLE

What hobbies or activities do you do regularly? (ex: sewing, reading, golf, etc.)

Do you use a computer more than 6 hours per day? Y N

Do you regularly experience eyestrain/fatigue, headaches/neck aches while on the computer/reading? Y N

Do you wear sunglasses while outdoors? Y N

HEALTH HISTORY

Do you have any of the following? (you MUST mark none if appropriate)

General

- Fever
- Weight Loss
- Weight Gain
- Fatigue
- Other _____
- None

Ear/Nose/Throat

- Sinus
- Dry Mouth/Dry Throat
- Cough
- Other _____
- None

Cardiovascular

- High Blood Pressure**
- Heart Surgery
- Stroke
- Vascular Disease
- Other _____
- None

Respiratory

- Asthma
- Bronchitis
- COPD
- Emphysema
- Other _____
- None

Genital/Kidney/Bladder

- Urinary Tract Infection
- Kidney Stones
- STD
- Other _____
- None

Muscles/Joints/Bones

- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Joint/Muscle Pain
- Other _____
- None

Skin

- Acne
- Eczema
- Rosacea
- Other _____
- None

Neurologic

- Migraines
- Headaches
- Seizures
- Multiple Sclerosis
- Other _____
- None

Psychiatric

- Depression
- Anxiety
- Insomnia
- Other _____
- None

Endocrine

- Thyroid Dysfunction
- Diabetes**
- Hormone Dysfunction
- Other _____
- None

Blood/Lymph

- Anemia
- Leukemia
- Bleeding disorder
- High Cholesterol**
- Other _____
- None

Allergic/Immunologic

- Seasonal Allergies**
- Lupus
- AIDS/HIV
- Other _____
- None

Gastrointestinal

- Crohn's Disease
- Colitis
- Hepatitis
- Other _____
- None

Any other condition not listed above: _____

Have your parents, grandparents, or siblings had any of the following?

- Cancer
- High Blood Pressure
- Diabetes
- Heart Disease

HIPAA NOTICE AND ACKNOWLEDGMENT

I have been presented a copy of the Privacy Practices and have been offered a copy for my records.

Printed Name: _____

Signature: _____

CONSENT TO TREAT

I hereby give my consent to Desert EyeCare Center to provide eye care services to myself and/or family.

Signature: _____