Name_____

Today's Date_____Age_____

Patient Medical History

Primary Care Physician_____

Phone Number_____

Date of Last Visit_____

Previous Eye Physician_____

Date of Last Eye Exam_____

*Have **YOU** ever been diagnosed with or had problems with any of these systems?*

❑ Diabetes Type _____ When diagnosed? _____

❑ High Blood Pressure When diagnosed? _____

❑ Cancer What type?_____

❑ Migraine Headaches
❑ Ear/Nose/Throat
❑ Endocrine (Glands)
❑ Cardiovascular
❑ Blood/Lymphatic
❑ Respiratory
❑ Depression/Psychiatric
❑ Thyroid
❑ Gastrointestinal
❑ Skin
❑ Muscle/Bone
❑ Immunological
❑ Neurological
❑ Cholesterol

Are You Currently…

❑ Pregnant
❑ Nursing
❑ A Smoker

Please Explain_____

_____

Current Medications _____

_____

Other Issues Not Listed Above_____

_____

Major Surgeries_____

❑ **Allergies to Medications _____**

Other Allergies_____

Family Eye/Medical History

	Who? Which Side?
❑ Heart Disease	_____
❑ Diabetes	_____
❑ Cancer (Type)_____	_____
❑ Blindness	_____
❑ Cataracts	_____
❑ Glaucoma	_____
❑ Corneal Problems	_____
❑ Lazy/Turned Eye	_____
❑ Macular Degeneration	_____
❑ Retinal Disease	

Patient Eye History

Explain Your Vision Difficulties_____

_____

❑ Floaters
❑ Dryness
❑ Arms Are Not Long Enough
❑ Flashes of Light
❑ Redness

Others_____

❑ I do ***NOT*** currently wear Glasses or Contact Lenses
❑ I am interested in Contact Lenses

I need/want to wear corrective lenses for

❑Distance/Driving
❑Near/Reading
❑Sport
❑Computer Work

*Have **YOU** been diagnosed or have experienced:*

❑ Glaucoma
❑ Lazy Eye/Amblyopia
❑ Color Deficiency
❑ Macular Degeneration
❑ Iritis/Uveitis
❑ Cataracts
❑ Eye Turn/Strabismus
❑ Loss of Vision
❑ Dry Eye
❑ Ocular Herpes

❑ Retinal Disease_____

❑ Corneal Problems_____

Other_____

❑ Eye Surgeries _____Date_____

❑ Eye Injuries_____Date_____

_____

Current Eye Drop Prescriptions, over the counter eye drops or vitamins used_____

_____

❑ Work at a Computer? How many hours_____

❑ Any Water Sports? What type_____

❑ Wear Protective Eyewear for Sports or Work? _____

❑ Current glasses have Anti-Reflective Coating? _____

Contact Lenses…

❑ Soft ❑ RGP

Brand_____

How often do you REPLACE lenses? _____

How often do you REMOVE lenses from eye?_____

How old are the lenses you are wearing today?_____

Comfort ❑ Excellent ❑ OK ❑Poor

Convenience ❑ Excellent ❑ OK ❑Poor

Do you have a pair of current back-up Glasses? _____

OFFICE USE ONLY

APPT_____IN _____WEEKS