PATIENT HISTORY

Dear patients: We wish we didn't have to ask you to fill this out, but it makes it easier if you take the time to fill this out accurately.

Name: _____ **Date**: _____

What is the main reason for today's exam? _____

Approximately how long ago was your last exam? _____

Current Medications (prescription/over the counter):

_____

_____

_____

Current Eye Drops (prescription/over the counter):

_____

_____

_____

Allergies (Drug/Environmental/Food): □ Yes □ No

If Yes, please list _____

Do you smoke tobacco products? □ Yes □ No

Do you drink alcohol? □ Yes □ No

EYE HISTORY

□ Glaucoma	□ Strabismus (Crossed Eyes)		
□ Cataract	□ Excess Tearing/Watering	□ Blurred Vision Distance	□ Dryness
□ Macular Degeneration	□ Eye Pain or Soreness	□ Blurred Vision Near	□ Tired Eyes
□ Retinal Detachment	□ Foreign Body Sensation	□ Distorted Vision (halos)	□ Itching
□ Color Blindness	□ Infection of Eye or Lid	□ Double Vision	□ Burning
□ Mucous Discharge	□ Floaters or Spots	□ Refractive Surgery (Lasik)	□ Redness
□ Glare/Light Sensitivity	□ Fluctuating Vision	□ Drooping Eyelid	□ Loss of Vision
□ Amblyopia (Lazy Eye)	□ Loss of Side Vision	□ Sandy or Gritty Feeling	□ Headaches

□ Injury/Trauma Describe: _____

GENERAL HEALTH HISTORY

□ Weight Loss	□ Muscles, Bones, Joints	□ Blood/Lymph	□ Fever
□ Cardiovascular	□ Endocrine (Thyroid, Diabetes)	□ Allergic	□ Kidney
□ Respiratory (Asthma)	□ Neurological (Multiple Sclerosis)	□ Skin Disease	
□ Gastrointestinal	□ Anxiety or Depression	Are you? □ Pregnant	□ Nursing

(Please turn over)

FAMILY HISTORY

□ Amblyopia	□ Retinal Detachment	□ Arthritis	□ Heart Disease	□ Lupus
□ Blindness	□ Strabismus (Eye Turn)	□ Kidney Disease	□ Glaucoma	□ Others
□ Cataract(s)	□ Macular Degeneration	□ Thyroid Disease	□ Diabetes	
□ Color Blindness	□ High Blood Pressure	□ Cancer	□ Stroke	

SPECTACLE LENS HISTORY

Do you use a computer? □ Yes □ No Hours per day? _____ Do you currently wear glasses? □ Yes □ No
Glasses Owned □ Single Vision □ Bifocals □ Trifocals □ Progressive □ Computer Glasses □ Sun Glasses
Special Eyewear Needs □ Eye Glasses □ Computer Glasses □ Safety Glasses □ Sports Glasses
I would like information on: □ Laser Vision Correction □ Corneal Refraction Therapy (CRT) □ Vision Therapy

CONTACT LENS HISTORY

Do you currently wear contact lenses? □ Yes □ No Since _____
Will today's exam include a new or updated contact lens prescription? □ Yes □ No
Type and brand of contact lenses _____ Replacement Cycle _____
How many hours/day? _____ How many days/week? _____ Overnight wear? □ Yes □ No
I would like information on: □ Bifocal Contact Lenses □ Lenses for Astigmatism
□ Lenses for Dry Eyes □ Daily Disposables
If not a contact lens wearer, are you interested in trying contact lenses at this time? □ Yes □ No
Would you like to change or enhance your eye color? □ Yes □ No
Do you ever experience either 'halos or glare' □ Yes □ No Especially at night? □ Yes □ No