Patient's Name:

PERSONAL HEALTH HISTORY:

What is the main reason for your visit today?_____

When was your last eye exam? _____

When was your last medical exam? _____

What is the name of your Primary Care Physician?_____

Past Illnesses or injuries: _____

Past Surgeries: _____

Current Medications:_____

Current Eye Drops: _____

Allergies to medications?_____

Severity to allergy? Please Circle: Very Mild, Mild, Moderate, Severe
Please describe allergic reaction: _____

PERSONAL EYE HISTORY:

Glaucoma:	○ Yes	○ No
Cataract:	○ Yes	○ No
Macular degeneration:	○ Yes	○ No
Retinal Detachment:	○ Yes	○ No

Color Blindness?	○ Yes	○ No
Headaches:	○ Yes	○ No
Glare/ Light Sensitivity:	○ Yes	○ No
Tired Eyes:	○ Yes	○ No

PHYSIOLOGIC

Amblyopia (Lazy Eye):	○ Yes	○ No
Burning:	○ Yes	○ No
Dryness:	○ Yes	○ No
Excess Tearing/Watering:	○ Yes	○ No
Eye Pain or Soreness:	○ Yes	○ No
Foreign Body Sensation:	○ Yes	○ No
Infection of Eye or Lid:	○ Yes	○ No
Itching:	○ Yes	○ No
Mucous Discharge:	○ Yes	○ No
Drooping Eyelid:	○ Yes	○ No
Redness:	○ Yes	○ No
Sandy/Gritty Feeling:	○ Yes	○ No
Strabismus (Crossed Eyes):	○ Yes	○ No

VISUAL SYMPTOMS

Blurred Vision Distance:	○ Yes	○ No
Blurred Vision Near:	○ Yes	○ No
Distorted Vision (halos):	○ Yes	○ No
Double Vision:	○ Yes	○ No
Floaters/Spots:	○ Yes	○ No
Fluctuation Vision:	○ Yes	○ No
Loss of Vision:	○ Yes	○ No
Loss of Side Vision:	○ Yes	○ No

SOCIAL HISTORY:

What's your current occupation?_____

How many hours do you spend on the computer? _____

Distance to computer? _____

Any special eyewear needs? (Such as Computer, Occupational, Safety Glasses Sports/Hobbies)_____

Hobbies/Interests: _____

GENERAL HEALTH:

Fever:	o Yes	o No
Weight Loss:	o Yes	o No
Other Symptoms:	o Yes	o No
Ears, Nose Throat:	o Yes	o No
Cardiovascular (High Blood Pressure, Etc) :	o Yes	o No
Respiratory (Asthma):	o Yes	o No
Gastrointestinal:	o Yes	o No
Kidney:	o Yes	o No
Muscle, Bones, Joints:	o Yes	o No
Skin:	o Yes	o No
Neurological (Multiple Sclerosis):	o Yes	o No
Anxiety or Depression:	o Yes	o No
Thyroid:	o Yes	o No
Diabetes:	o Yes	o No
Blood/Lymph:	o Yes	o No
Cholesterol:	o Yes	o No
Allergic:	o Yes	o No
Pregnant:	o Yes	o No
Nursing:	o Yes	o No

FAMILY HISTORY:

Amblyopia (Lazy Eye):	o Yes	o No
Blindness:	o Yes	o No
Cataract(s):	o Yes	o No
Color Blindness:	o Yes	o No
Glaucoma:	o Yes	o No
Macular Degeneration:	o Yes	o No
Retinal Detachment:	o Yes	o No
Strabismus (Eye Turn):	o Yes	o No
Arthritis:	o Yes	o No
Cancer:	o Yes	o No
Diabetes:	o Yes	o No
Heart Disease:	o Yes	o No
High Blood Pressure:	o Yes	o No
Kidney Disease:	o Yes	o No
Lupus:	o Yes	o No
Stroke:	o Yes	o No
Thyroid Disease:	o Yes	o No
Other _____		

CONTACT LENS HISTORY:

Are you interested in trying contact lenses at this time? _____

Have you ever tried to wear contact lenses? _____

Do you currently wear contacts? _____ Brand of current contacts? _____

How many hours do you wear your contacts per day? _____

Today's wearing time? _____

Do you sleep with your contact on? _____

How often do you replace your contacts? _____

What solutions do you use? _____

SOCIAL HISTORY:

Do you drive?	o Yes	o No
Do you have visual difficulty when driving?	o Yes	o No
Do you have problems with night vision?	o Yes	o No
Do you have glare problems?	o Yes	o No
Do you currently wear glasses?	o Yes	o No
Have you had trouble with glasses in the past?	o Yes	o No
Do you wear sunglasses?	o Yes	o No

Do you drink alcohol?

If yes, how much/often: o No o Occasional o 1 Per day o 2-3 /Day o 4+ /day

Do you smoke?

o Never oFormer Smoker oCurrent Every Day Smoker oCurrent Some Day Smoker