



EYE HEALTH HISTORY

If new to our office, date of last eye exam _____ Name of previous eye doctor _____

Do you wear glasses: Yes No

All the time Occasionally Reading Driving

Do you wear contacts: Yes No Type _____ Hours/Day _____

Describe any problems you have with your contacts: _____

Are you interested in wearing contacts? Yes No

Place a mark on "Yes" or "No" to indicate if you had any of the following:

Blurred Vision with Glasses- Distance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Crossed Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blurred Vision with Glasses - Near	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic Infection of Eye or Lid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Strain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Burning Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Floater or Spots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dry Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seeing Flashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Discharge from Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seeing Halos	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Light Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

MEDICAL HEALTH HISTORY

Date of last medical exam _____ Name of medical doctor _____

Place a mark on "Yes" or "No" to indicate if you had any of the following:

	Yourself		Family Members			Yourself		Family Members	
Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lazy Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Retinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis (type) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthmas	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No					

Are you pregnant? Yes No Due Date _____ Tobacco Use Yes No

Number of Children _____ Alcohol Use Yes No

List your allergies to medications or other substances: _____

List medications you are currently taking, including eye drops: _____