

LAST NAME _____ FIRST _____ DATE OF BIRTH _____

OCCUPATION/STUDENT _____

FAMILY DR.'S NAME _____

DOCTORS ADDRESS _____

REASON FOR VISIT: Briefly describe any problems you are having with your eyes or vision

Do you use a computer, if yes, how many hours per day? _____

Participate in sports, please list _____

Currently wear contact lenses Interested in wearing contact lenses

Do you typically wear sunglasses when out in the sun? Yes No

Are you bothered by glare with night driving? Yes No

Are you happy with your current eyeglasses? Yes No

PAST AND PRESENT MEDICAL HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> thyroid disorder | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> sinus infections | <input type="checkbox"/> neurological / headaches |
| <input type="checkbox"/> Cholesterol (elevated) | <input type="checkbox"/> blood disorder | <input type="checkbox"/> head injury |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> cancer | <input type="checkbox"/> anxiety/ depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> immune/infectious disease | <input type="checkbox"/> respiratory / asthma |
| <input type="checkbox"/> Pituitary disorder | <input type="checkbox"/> skin disease | |

EYE HISTORY – WRITE “S” FOR SELF, AND “F” FOR FAMILY

- | | | |
|---|--|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> eye surgery | <input type="checkbox"/> eye injury |
| <input type="checkbox"/> Glaucoma or suspect | <input type="checkbox"/> lazy / turned eye | <input type="checkbox"/> retinal defect/ detachment |
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> floating spots | <input type="checkbox"/> dry/ itchy/ irritated eyes |

SOCIAL HISTORY tobacco use alcohol / drug use

Recent Illness (please describe) _____

OTHER MEDICAL OR EYE CONDITIONS _____

MEDICATIONS (include eye-drops and over-the-counter) _____

DRUG ALLERGIES _____

ENVIRONMENTAL ALLERGIES _____