

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** \_\_\_\_\_

**ALL MEDICATIONS** (include eye-drops and over-the-counter)

\_\_\_\_\_  
\_\_\_\_\_

**DRUG ALLERGIES** \_\_\_\_\_

**ENVIRONMENTAL ALLERGIES** \_\_\_\_\_