Patient Name:_____ **DOB:**_____ **Date:**_____

Eye History

Date of Last Eye Exam _____/_____/_____

Currently Wear Glasses? Yes or No

Currently Wear Contacts? Yes or No

Reason For Today's Visit:_____

_____

Are you experiencing any of the following symptoms?

- ☐ Blurry Vision (Near / Distance)
- ☐ Floaters/Spots
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Pain or Soreness
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

Medical History

Current Medications
(Prescription and/or over-the-counter and dosage)
*If lengthy you can attach a separate piece of paper

_____

_____

_____

_____

_____

Medication/Drug Allergies

_____

_____

Surgical History

Ocular Surgical History (Please list procedures and dates)

_____

_____

_____

_____

Systemic Surgical History (Please list procedures and dates):

_____

_____

_____

_____

Height:_____ **Weight:**_____

Are you pregnant or nursing? Yes or No

Do you currently smoke? Yes or No

Have you ever smoked? Yes or No

If you have stopped smoking, how long since you last smoked? _____

Do you drink? Yes or No **If yes, please circle one of the following: Socially 1-2 daily More than 1-2 daily**

Medical History Continued…

Have you or a family member experienced or been treated for any of the following?

Please Circle all that apply.

Cataracts:	**Self** Mother Father Child Aunt Uncle Maternal: Grandma / Grandpa Paternal: Grandma/ Grandpa
Glaucoma:	**Self** Mother Father Child Aunt Uncle Maternal: Grandma / Grandpa Paternal: Grandma/ Grandpa
Lazy Eye/Crossed Eye:	**Self** Mother Father Child Aunt Uncle Maternal: Grandma / Grandpa Paternal: Grandma/ Grandpa
Macular Degeneration:	**Self** Mother Father Child Aunt Uncle Maternal: Grandma / Grandpa Paternal: Grandma/ Grandpa
Retinal Detachment:	**Self** Mother Father Child Aunt Uncle Maternal: Grandma / Grandpa Paternal: Grandma/ Grandpa
Cancer:	**Self** Mother Father Child Aunt Uncle Maternal: Grandma / Grandpa Paternal: Grandma/ Grandpa
Diabetes:	**Self** Mother Father Child Aunt Uncle Maternal: Grandma / Grandpa Paternal: Grandma/ Grandpa
Heart Disease:	**Self** Mother Father Child Aunt Uncle Maternal: Grandma / Grandpa Paternal: Grandma/ Grandpa
High Blood Pressure:	**Self** Mother Father Child Aunt Uncle Maternal: Grandma / Grandpa Paternal: Grandma/ Grandpa
Stroke:	**Self** Mother Father Child Aunt Uncle Maternal: Grandma / Grandpa Paternal: Grandma/ Grandpa

Have you experienced or been treated for any of the following?

Please circle yes or no.

Allergies	Yes or No
Ear, Nose and Throat Conditions	Yes or No
Gastrointestinal:	Yes or No
Arthritis:	Yes or No
Asthma:	Yes or No
High Cholesterol:	Yes or No
Kidney Disease:	Yes or No
Lupus:	Yes or No
Neurological Conditions:	Yes or No
Psychiatric Disorder(s):	Yes or No
Seizures:	Yes or No
Skin Conditions:	Yes or No
Thyroid Function:	Yes or No
Blood/Lymph Disorder:	Yes or No
HIV/AIDS	Yes or No