

MEDICAL HISTORY

Reason for today's visit: _____ Date of last eye exam _____

Name and address of former eye care provider: _____

Name of Primary Care Physician _____ Phone: _____

Address: _____ City: _____ State _____ Zip: _____

OCULAR HISTORY:

Please check any of the following conditions that apply to you:

- Decreased distance vision Floaters Eye injury Dryness Ocular Allergies
- Decreased near vision Flashes Eye surgery Redness Other _____
- Sore, tired eyes Glare Lazy eye Itching _____
- Night driving Double vision Focus problems Tearing None

MEDICAL HISTORY:

Do you or anyone in your immediate family have a history of the following?

- | | | | |
|---|---|--|--|
| <i>Self/Family</i> | <i>Self/Family</i> | <i>Self/Family</i> | <i>Self/Family</i> |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Asthma | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Nervous problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Fainting | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart/Circulatory Prob | <input type="checkbox"/> Swelling of feet/ankles | <input type="checkbox"/> None |

Please describe: _____

Staff Verified

Doctor Verified

Are you taking any medications? Yes No

Please list medications: _____

Do you have any allergies to medication? Please list: _____

CONTACT LENS HISTORY:

Do you wear contact lenses now or have you worn them in the past? _____

Type: _____ RGP Soft Disposable Soft Daily

Do you have any unusual visual requirements at work? (i.e.: computer, fine close work, glare or special bifocal requirements)? _____

Do you have any special requirements related to sports or hobbies (i.e.: golf, fishing, hiking, ball sports, or biking)? _____

Whom may we thank for referring you? _____

Immediate family members who are patients here: _____

I WOULD LIKE TO KNOW MORE ABOUT:

- Prescription eyewear Contact lenses Laser vision correction Vision shaping treatment
- Prescription sunglasses Being a subject in a clinical study