

PLEASE COMPLETE THE FOLLOWING HEALTH HISTORY

Reason for today's visit: _____

Occupation: _____ When was your last eye exam? _____ Where? _____

Do you presently wear glasses? Yes No Full time Distance Only Reading Only Computer

Do you wear contact lenses? Yes No If yes, what brand? _____

Are you experiencing any of the following eye/vision problems? (Please circle all that apply)

- Itchy eyes Watery eyes Flashes
- Pain/Soreness Tired eyes Floaters
- Red Eye Light Sensitivity Headaches
- Burning Stinging Blurred Vision Previous eye injury _____
- Discharge Double Vision Previous eye surgery _____
- Dryness/Sandy/Gritty Loss of Vision Other (describe) _____

Have **YOU** ever been diagnosed as having any of the following?

- | | | | | | |
|--------------------------------|--|------------|---------------------|--|------------|
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ | Respiratory | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ |
| Macular Degeneration | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ |
| Lazy Eye | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ | Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ | Thyroid | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ |
| Retinal Detachment/
Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ | Other (describe) | _____ | |

Has **anyone in YOUR FAMILY** ever been diagnosed as having any of the following?

- | | | | | | |
|--------------------------------|--|-----------|------------------------|--|-----------|
| Blindness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Who _____ | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Who _____ |
| Macular Degeneration | <input type="checkbox"/> Yes <input type="checkbox"/> No | Who _____ | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Who _____ |
| Retinal Detachment/
Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Who _____ | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Who _____ |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Who _____ | High Blood
Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Who _____ |

Are you currently taking any medications? (Prescription, non-prescription, home remedies, vitamins) **NONE**

- | | | | |
|----------|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ | 7. _____ |
| 2. _____ | 4. _____ | 6. _____ | 8. _____ |

Do you have any allergies to medication/anesthesia or anything else? Circle one: **NO** or **YES (if yes list below)**

- | | | |
|--|-----|----|
| Do you smoke? | Yes | No |
| Are you pregnant? | Yes | No |
| Are you interested in finding out about contact lens options for yourself? | Yes | No |
| Are you interested in finding out about laser vision correction? | Yes | No |

Signature: _____ Date: _____