Patient Name: ________________________________ **Date**: _________________________

EYE HISTORY

Do you have the following?

Blurred vision	□ yes	□ no	**Loss of vision**	□ yes	□ no	**Double vision**	□ yes	□ no
Lazy Eye/Turn	□ yes	□ no	**Color Blindness**	□ yes	□ no	**Light sensitivity**	□ yes	□ no
Glare	□ yes	□ no	**Floaters**	□ yes	□ no	**Flashes**	□ yes	□ no
Headaches	□ yes	□ no	**Lid Spasms**	□ yes	□ no	**Itchy eyes**	□ yes	□ no
Watering eyes	□ yes	□ no	**Redness**	□ yes	□ no	**Burning**	□ yes	□ no
Dry Eyes	□ yes	□ no	**Cataracts**	□ yes	□ no	**Retinal Disease**	□ yes	□ no
Macular Degeneration	□ yes	□ no	**Glaucoma**	□ yes	□ no	**Other** __________________		

Have you had any eye surgery? □ Yes □ No List All ______________________________________

Do you have any family history of? □ Blindness □ Cataracts □ Glaucoma □ Lazy or eye turn □ Macular degeneration □ Retinal disease □ Other____________

MEDICAL HISTORY

Check if you or any family members have the following:

	YOU		**FAMILY**		
Allergies	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Arthritis	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Asthma	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Cancer	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Cholesterol	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Diabetes	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Heart disease	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Hepatitis	□ yes	□ no	□ yes	□ no	Relation: ________________________________
HIV/ AIDS	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Hypertension	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Kidney Disease	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Lupus	□ yes	□ no	□ yes	□ no	Relation: ________________________________
M.S.	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Sjogren's	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Stroke	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Thyroid	□ yes	□ no	□ yes	□ no	Relation: ________________________________
Tuberculosis	□ yes	□ no	□ yes	□ no	Relation: ________________________________

Other: ____

PLEASE FILL OUT FRONT AND BACK OF FORM

Are you taking any medication? □ Yes □ No List all ____

____

Are you taking any eye medications? □ Yes □ No List All ____

Are you allergic to any medication? □ Yes □ No List all ____

____

List any surgeries you have had: ____

Height: ____________________

Weight: ____________________

Blood pressure: _____/_______ **Date:** ______________

Do you drink alcohol: □ yes □ no choose one □ socially □ daily □ above average

Tobacco use: □ yes □ no approximately how many years: __________

Former Smoker: □ yes □ no quit smoking how long ago? _____________

Have you ever had a Blood Transfusion? □ yes □ no

Do you have or have you ever had a Sexually Transmitted Disease? □ yes □ no

Females Only

Are you pregnant? □ yes □ no **If yes, how many Weeks?** ___________

Are you nursing? □ yes □ no

Diabetics only

Last blood sugar: ______________________________

Average fasting blood sugar: ____________________

Hemoglobin A1C: ______________________________

Do you drive? □ yes □ no

Do you have trouble seeing when driving at night? □ yes □ no

Do you wear glasses? □ Yes □ No □ Distance only □ Reading only □ Bifocal/Progressive

Do you use a computer? □ Yes □ No How many hours a day? ________________________________

Do you wear contacts? □ Yes □ No □ Soft Lenses □ Hard Lenses □ Overnight

If yes, are you having trouble with: □ Dryness □ Itchiness □ Redness □ Poor vision

Name of Contacts: ____________________ **Power:** Right Eye_________________ Left Eye____________________

How many hours do you wear your contacts on a daily basis? ____

How many days a week do you wear your contacts? ____

How many hours have your contacts been in your eyes today? ____

What type of Storing/Cleaning solution do you use? ____

Do you use contact lens lubricating drops? □ Yes □ No **If yes how many times a day?** ________________

Patient's (or Guardian) Signature: ____ **Date:** ____________________