Patient Name: _____ Date: _____

Please indicate with a check (✓) if you have any of the following:

Blurred vision ☐ yes ☐ no Loss of vision ☐ yes ☐ no Double vision ☐ yes ☐ no Glare ☐ yes ☐ no

Color Blindness ☐ yes ☐ no Light Sensitivity ☐ yes ☐ no Headaches ☐ yes ☐ no Floaters ☐ yes ☐ no

Flashes ☐ yes ☐ no Lid Spasms ☐ yes ☐ no Burning ☐ yes ☐ no Dry eyes ☐ yes ☐ no

Watering eyes ☐ yes ☐ no Itchy eyes ☐ yes ☐ no Other: _____

Do you drive: ☐ yes ☐ no Do you have trouble seeing when driving at night: ☐ yes ☐ no

Do you wear glasses: ☐ yes ☐ no Are you having blurry vision with your glasses: ☐ yes ☐ no

Do you use a computer: ☐ yes ☐ no How many hours a day: _____

Do you wear contacts: ☐ yes ☐ no ☐ Soft lens ☐ Hard lens ☐ Overnight/Ortho K lens

Contact lens brand: _____ Power: Right eye: _____ Left eye: _____

If yes, how many hours daily: ____ How many days a week: _____ How long have they been in today: _____

Are you having blurry vision with your contacts: ☐ yes ☐ no

What type of storing/disinfecting solution do you use: _____

Females only:

Are you pregnant? ☐ yes ☐ no If yes, how many weeks? _____

Are you nursing? ☐ yes ☐ no

Family Eye History: Please indicate with a check (✓) who in your family has or has had the following conditions.

	Self	Mother	Father	Siblings	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother
Blindness	☐	☐	☐	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Lazy eye	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐

Other:

PLEASE CONTINUE ON THE BACK →

Medical History: Please indicate with a check (✓) who in your family has or has had the following conditions.

	Self	Mother	Father	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother
Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐	☐	☐
M.S.	☐	☐	☐	☐	☐	☐	☐	☐
Sjogren's	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐
Other:								

Height: _____ **Weight:** _____ **lbs**

Have you ever had any surgeries: ☐ yes ☐ no **If yes, please list all:** _____

_____

Have you ever had blood transfusion: ☐ yes ☐ no

Do you have or have you ever had a sexually transmitted disease: ☐ yes ☐ no

Are you using any eye medications (including lens lubricating drops): ☐ yes ☐ no **If yes, please list all:** _____

_____

Are you taking any medications (including vitamins): ☐ yes ☐ no **If yes, please list all:** _____

_____

Are you allergic to any medication(s): ☐ yes ☐ no **If yes, please list all:**_____

_____

Tobacco use: ☐ yes ☐ no **How many years:** _____ **Former smoker:** ☐ yes ☐ no **How long ago:** _____

Do you drink alcohol: ☐ yes ☐ no **Choose one** ☐ socially ☐ daily ☐ above average

Diabetic or Borderline Diabetic patients only:

Last blood sugar: _____ Average fasting blood sugar: _____ Hemoglobin A1C: _____

Parent or Guardian Signature: _____ Date: _____