PATIENT HEALTH HISTORY

PATIENT NAME: ____________________________________

DATE: ____

EYE HISTORY

DO YOU CURRENTLY WEAR GLASSES?	Y / N
DO YOU CURRENTLY WEAR CONTACTS?	Y / N
ARE YOU INTERESTED IN CONTACTS?	Y / N
DO YOU HAVE VISUAL DIFFICULTY WHEN READING?	Y / N
DO YOU HAVE VISUAL DIFFICULTY WHEN DRIVING?	Y / N

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

CATARACTS	YES	NO	FAMILY
CROSSED EYES	YES	NO	FAMILY
GLAUCOMA	YES	NO	FAMILY
LASER SURGERY	YES	NO	FAMILY
LAZY EYE	YES	NO	FAMILY
MACULAR DEGENERATION	YES	NO	FAMILY
RETINAL DETACHMENT	YES	NO	FAMILY

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ BLURRY VISION near or distance
- ☐ BURNING
- ☐ DISCHARGE
- ☐ DOUBLE VISION
- ☐ DROOPING EYELID
- ☐ DRYNESS
- ☐ EXCESS TEARING/WATERING
- ☐ EYE INFECTION
- ☐ EYE PAIN OR SORENESS
- ☐ FLOATERS OR SPOTS
- ☐ FOREIGN BODY SENSATION
- ☐ HALOS
- ☐ HEADACHES
- ☐ ITCHING
- ☐ LIGHT FLASHES
- ☐ LIGHT SENSITIVITY
- ☐ REDNESS
- ☐ SANDY OR GRITTY FEELING

Have you ever had eye surgery? Y / N (if yes, please explain)

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____

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	YES	NO	FAMILY
ALLERGIES	YES	NO	FAMILY
ARTHRITIS (RHEUMATOID)	YES	NO	FAMILY
ASTHMA	YES	NO	FAMILY
BLOOD/LYMPH DISORDER	YES	NO	FAMILY
CANCER	YES	NO	FAMILY
DIABETES	YES	NO	FAMILY
EARS, NOSE, THROAT CONDITIONS	YES	NO	FAMILY
GASTROINTESTINAL CONDITIONS	YES	NO	FAMILY
HEART DISEASE	YES	NO	FAMILY
HIGH BLOOD PRESSURE	YES	NO	FAMILY
HIGH CHOLESTEROL	YES	NO	FAMILY
KIDNEY DISEASE	YES	NO	FAMILY
LUPUS	YES	NO	FAMILY
NEUROLOGICAL CONDITIONS	YES	NO	FAMILY
PSYCHIATRIC DISORDER	YES	NO	FAMILY
SEIZURES	YES	NO	FAMILY
SKIN CONDITIONS	YES	NO	FAMILY
STROKE	YES	NO	FAMILY
THYROID DYSFUNCTION	YES	NO	FAMILY

CURRENT MEDICATIONS

(Please list prescription and over-the-counter)

____

____

____

____

MEDICATION DRUG ALLERGIES

____

____

PHARMACY

NAME: ____

PHONE #: ______________________________________

PRIMARY CARE PHYSICIAN

NAME: ____

CITY: ____

PHONE #: ______________________________________

Are you currently pregnant or nursing? Y / N

Do you currently use the following? Circle all that apply.

CIGARETTES	SMOKELESS TOBACCO
ALCOHOL	RECREATIONAL DRUGS