Patient: _____ Date: _____
(Last) (First) (M.I.)

Date of Birth: _____ Age: _____

EYE HEALTH HISTORY

Date of last eye exam _____

Name of doctor _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type _____ Hours/Day_____

Describe any problems you have with your contacts _____

_____

_____

Place a mark on "Yes" to indicate if you have had any of the following:

Bloodshot Eyes	☐ Yes	Floaters or Spots	☐ Yes
Blurred Vision - Distance	☐ Yes	Glaucoma	☐ Yes
Blurred Vision - Near	☐ Yes	Headaches	☐ Yes
Burning Eyes	☐ Yes	Itching Eyes	☐ Yes
Cataracts	☐ Yes	Light Sensitive	☐ Yes
Color Vision, Poor	☐ Yes	Loss of Vision	☐ Yes
Crossed Eyes	☐ Yes	Migraine Headaches	☐ Yes
Discharge from Eyes	☐ Yes	Night Vision, Poor	☐ Yes
Dizzy Spells	☐ Yes	Red Eyes	☐ Yes
Double Vision	☐ Yes	Seeing Halos	☐ Yes
Dry Eyes	☐ Yes	Seeing Flashes	☐ Yes
Eye Infection	☐ Yes	Temporary Loss of Vision	☐ Yes
Eye Injury	☐ Yes	Twitching Eyelid	☐ Yes
Eye Strain	☐ Yes	Vision Poor	☐ Yes
Fainting Spells, Blackouts	☐ Yes	Watering Eyes	☐ Yes

HEALTH HISTORY

Family Physician's Name _____ Date of last visit _____

Place a mark on "Yes" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	☐ Yes	☐ Yes	High Blood Pressure	☐ Yes	☐ Yes
Arthritis	☐ Yes	☐ Yes	Kidney Disease	☐ Yes	☐ Yes
Artificial Heart Valve	☐ Yes	☐ Yes	Lazy Eye	☐ Yes	☐ Yes
Artificial Joints	☐ Yes	☐ Yes	Lupus	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Macular Degeneration	☐ Yes	☐ Yes
Bleeding	☐ Yes	☐ Yes	Migraine Headaches	☐ Yes	☐ Yes
Blindness	☐ Yes	☐ Yes	Pacemaker	☐ Yes	☐ Yes
Cancer	☐ Yes	☐ Yes	Poor Color Vision	☐ Yes	☐ Yes
Cataracts	☐ Yes	☐ Yes	Retinal Disease	☐ Yes	☐ Yes
Chemical Dependency	☐ Yes	☐ Yes	Rheumatic Fever	☐ Yes	☐ Yes
Diabetes	☐ Yes	☐ Yes	Shingles	☐ Yes	☐ Yes
Drug Sensitivity	☐ Yes	☐ Yes	Skin Conditions	☐ Yes	☐ Yes
Emphysema	☐ Yes	☐ Yes	Stroke	☐ Yes	☐ Yes
Epilepsy	☐ Yes	☐ Yes	Thyroid Conditions	☐ Yes	☐ Yes
Eye Surgery	☐ Yes	☐ Yes	Tuberculosis	☐ Yes	☐ Yes
Glaucoma	☐ Yes	☐ Yes	Turned Eye	☐ Yes	☐ Yes
Hay Fever	☐ Yes	☐ Yes	Are you pregnant?_____	Number of Children _____	
Heart Condition	☐ Yes	☐ Yes	Tobacco use _____	Alcohol use _____	
Hepatitis (Type_____)	☐ Yes	☐ Yes	Other_____		

MEDICATIONS

List medications you are currently taking, including eye drops:

_____

_____

_____

Pharmacy Name _____

Phone_____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

_____