

EYE HEALTH HISTORY

Date of last eye exam _____

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

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 _____

- | | | | |
|----------------------------|------------------------------|--------------------------|------------------------------|
| Bloodshot Eyes | <input type="checkbox"/> Yes | Floaters or Spots | <input type="checkbox"/> Yes |
| Blurred Vision - Distance | <input type="checkbox"/> Yes | Glaucoma | <input type="checkbox"/> Yes |
| Blurred Vision - Near | <input type="checkbox"/> Yes | Headaches | <input type="checkbox"/> Yes |
| Burning Eyes | <input type="checkbox"/> Yes | Itching Eyes | <input type="checkbox"/> Yes |
| Cataracts | <input type="checkbox"/> Yes | Light Sensitive | <input type="checkbox"/> Yes |
| Color Vision, Poor | <input type="checkbox"/> Yes | Loss of Vision | <input type="checkbox"/> Yes |
| Crossed Eyes | <input type="checkbox"/> Yes | Migraine Headaches | <input type="checkbox"/> Yes |
| Discharge from Eyes | <input type="checkbox"/> Yes | Night Vision, Poor | <input type="checkbox"/> Yes |
| Dizzy Spells | <input type="checkbox"/> Yes | Red Eyes | <input type="checkbox"/> Yes |
| Double Vision | <input type="checkbox"/> Yes | Seeing Halos | <input type="checkbox"/> Yes |
| Dry Eyes | <input type="checkbox"/> Yes | Seeing Flashes | <input type="checkbox"/> Yes |
| Eye Infection | <input type="checkbox"/> Yes | Temporary Loss of Vision | <input type="checkbox"/> Yes |
| Eye Injury | <input type="checkbox"/> Yes | Twitching Eyelid | <input type="checkbox"/> Yes |
| Eye Strain | <input type="checkbox"/> Yes | Vision Poor | <input type="checkbox"/> Yes |
| Fainting Spells, Blackouts | <input type="checkbox"/> Yes | Watering Eyes | <input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Lazy Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Poor Color Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Retinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Shingles	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Drug Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Skin Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Thyroid Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Eye Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Turned Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Are you pregnant? _____	Number of Children _____	
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Tobacco use _____	Alcohol use _____	
Hepatitis (Type _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Other _____		

MEDICATIONS

List medications you are currently taking, including eye drops:

Pharmacy Name _____

Phone _____

ALLERGIES

List your allergies to medications or other substances:

