Patients Name: _____

Date: _____

Medical Eye History

Date of Last Eye Exam: _____/_____/_____ **By Dr.** _____

Have You Ever Worn Glasses? [ ] Yes [ ] No

How Are They Used? [ ] Distant [ ] Near [ ] Constant

Do You Wear Contact Lenses Now? [ ] Yes [ ] No
Type Worn? [ ] Daily Wear [ ] Disposable [ ] Extended Wear [ ] Astigmatism
[ ] Gas Permeable

Are You Interested in Contact Lenses? [ ] Yes [ ] No

What Is The Reason For Your Visit Today? (Please Check All That Apply.)

___ General Check-Up
___ Lost Or Broken Glasses
___ Blurred Distance Vision
___ Blurred Near Vision
___ Poor Night Vision
___ Other (explain)

___ Problem With Present Contacts
___ Eyes Burn Or Itch
___ Pain In The Eyes
___ Flashes Of Light
___ Spots Or Floaters

___ Headaches
___ Double Vision
___ Lazy Eye
___ Crossed Eye
___ Color Vision Problems

_____

_____

_____

Do You or Any Family Member Have . . .

	SELF	FAMILY
Glaucoma……..	[ ] Yes [ ] No	[ ] Yes [ ] No
Cataracts……	[ ] Yes [ ] No	[ ] Yes [ ] No
Diabetes……..	[ ] Yes [ ] No	[ ] Yes [ ] No
Migraine Headaches…….	[ ] Yes [ ] No	[ ] Yes [ ] No
Retinal Detachments……	[ ] Yes [ ] No	[ ] Yes [ ] No
High Blood Pressure……	[ ] Yes [ ] No	[ ] Yes [ ] No
Heart Trouble……	[ ] Yes [ ] No	[ ] Yes [ ] No
Kidney Trouble……..	[ ] Yes [ ] No	[ ] Yes [ ] No

Other Illnesses or Surgeries: _____

_____

Do You Have Any Problems With Any Of These Systems? (Please Circle)

Cardiovascular	Endocrine (Glands)	Allergic/Immune	Ear/Nose/Throat
Respiratory	Blood/Lymph	Gastrointestinal	Musculoskeletal
Nervous	Mental	Genitourinary	Integument (Skin**)**

Do You Use Any Of The Following: (Please Circle)

Cigarettes/Tobacco Alcohol Social Drugs

Have You Had Any Eye Surgery, Eye Injury or Eye Infections? If So, Give Type And Date:

_____

_____

_____

_____

Are You Allergic To Any Medications? [ ] Yes [ ] No

If So, Please List:

_____

_____

_____

Please List All Medications You Are Currently Taking:

_____

_____

_____

_____

_____

_____