The following confidential information is critical to the evaluation of your vision and health.

Patient Eye History

Date of Last Eye Exam: ________________________
By Whom? __________________________________
What is the major purpose of this visit?
____
Do you wear glasses? ☐ Yes ☐ No
If yes, how old is your present pair? _____________
Do you have any concerns about your current contact lenses or glasses?____________________________
Have you ever tried contact lenses? ☐ Yes ☐ No
Do you currently wear contact lenses? ☐ Yes ☐ No
If yes, please answer the following:

What kind? _________________________________
Solutions used?______________________________
Are you satisfied with the vision and comfort of your contact lenses? ☐ Yes ☐ No

Have you ever experienced, been diagnosed or treated for any of the following? (Check all that apply)

☐ Blurry Vision	☐ Floaters/Spots
☐ Burning	☐ Glaucoma
☐ Cataracts	☐ Iritis/Uveitis
☐ Chronic Headaches	☐ Itchiness
☐ Corneal Abrasions	☐ Lazy Eye
☐ Crossed Eye/Eye Turn	☐ Macular Degeneration
☐ Double Vision	☐ Occasional Dryness
☐ Eye Infections	☐ Retinal Detachment
☐ Eye Injury	☐ Sunlight Sensitivity
☐ Eye Surgeries	☐ Tearing
☐ Flash(es) of light	☐ Trouble seeing at night.

☐ Other_______________

Family Eye/Medical History

Please note relationship: Father's or Mother's side, siblings.

Blindness	☐ ____________________________
Cataracts	☐ ____________________________
Corneal Problems	☐ ____________________________
Diabetes	☐ ____________________________
Glaucoma	☐ ____________________________
Heart Disease	☐ ____________________________
High Blood Pressure	☐ ____________________________
Lazy Eye	☐ ____________________________
Lupus	☐ ____________________________
Macular Degeneration	☐ ____________________________
Retinal Problems	☐ ____________________________
Thyroid	☐ ____________________________
Other	☐ ____________________________

Patient Medical History

Name of Medical Doctor _________________________
Date of Last Physical Check-up ___________________

Current Medications (Rx or Over The Counter)
(Please list any medications you take including eye drops, vitamins, birth control pills and pain pills.)

Med:__________________	For:__________________
Med:__________________	For:__________________
Med:__________________	For:__________________
Med:__________________	For:__________________
Med:__________________	For:__________________
Med:__________________	For:__________________

Do you have any allergies to medications?
☐ Yes ☐ No
If yes, what medications?
____
Have you had any surgeries within the past year?
☐ Yes ☐ No
If yes, please describe:
____
____
Are you pregnant and/or nursing?
☐ Yes ☐ No ☐ N/A
Do you use:
☐ Alcohol ☐ Tobacco ☐ Cigarettes

Have you ever been diagnosed or treated for the following chronic health problems? (Check all that apply)

- ☐ Allergies/Hay fever
- ☐ Arthritis
- ☐ Blood/Lymph
- ☐ Cancer
- ☐ Cholesterol
- ☐ Diabetes
- ☐ Ears/Nose/Throat
- ☐ Endocrine (Thyroid and other glands)
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Integumentary (Skin)
- ☐ Kidney
- ☐ Muscle/Bone
- ☐ Neurological
- ☐ Psychological
- ☐ Respiratory
- ☐ Unusual weight losses/gains

Doctor Signature ____________________________ **Date** _______________