Name (Print)_____ Age _____ M / F Date _____

Reason for Today's Visit: _____ Any Special Eye or Vision Problems? _____

Occupation: _____ Hobbies: _____

What problems are you having with your **EYES**?	Yes (√)	No (√)	History of Present Symptoms (For Doctor/Staff)
Blurred Vision– Far/ Near/ Middle			
Sudden Vision Loss			
"Tired Eyes"			
Dryness of the Eye(s)			
Tearing / Redness / Discharge			
Itching / Burning / Gritty Feeling			
Eyelid Swelling			
Eye Turn/Crossed Eye/Lazy Eye			
History of Eye Injury / Surgery			
History of Seeing Floaters			
Glaucoma			
Any Other Eye Diseases			
Computer Use			Hours/day: Eye Strain Yes No
Wear Glasses			**Single Vision** – Distance or Near Vision / **Bifocals / Trifocals / Progressives**
Allergic to any Medications	Please List:		
Taking any Medications	Please List:		

Date of Last Eye Exam _____
Doctor _____

Date of Last Physical: _____
Doctor: _____
Phone Number: _____
Next Appt: _____

Pharmacy Name: _____
Phone Number: _____

Contact Lens Use for _____ years
Soft _____ DW _____
Rigid _____ EW _____
Hard _____ Flex _____
Type _____
Age of CLs _____
Comfortable Yes No
Solution(s)_____
Solution Allergies Yes No

Today I am Interested in: ☐ Glasses ☐ Sunglasses ☐ Contact Lenses - Clear / Colored ☐ LASIK

Females: Are you pregnant? ☐ Yes ☐ No ☐ Not Sure Are you nursing? ☐ Yes ☐ No

Personal Medical History

Mental Status	**Yes**	**No**
Depression	☐	☐
Anxiety	☐	☐
Other: _____		
Neurology		
Stroke	☐	☐
Seizures	☐	☐
Paralysis	☐	☐
Dizziness	☐	☐
Double Vision	☐	☐
Head		
Ear Problems	☐	☐
Sinus Problems	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Sinus/Allergies	☐	☐
Stress/Tension	☐	☐
w/ Eye Strain	☐	☐

Genitourinary	**Yes**	**No**
Kidney Problems	☐	☐
Bladder Problems	☐	☐
Prostate Problems	☐	☐
Cardiovascular		
Heart Disease	☐	☐
Enlarged Heart	☐	☐
Irregular Heart Beat	☐	☐
Shortness of Breath	☐	☐
High Blood Pressure	☐	☐
Hematology		
Anemia	☐	☐
HIV +	☐	☐
Hepatitis _____	☐	☐
Sickle Cell / Trait	☐	☐
Cancer	☐	☐
Muskuloskeletal		
Arthritis	☐	☐
Back Problems	☐	☐
Neck Problems	☐	☐

Pulmonary	**Yes**	**No**
Asthma	☐	☐
Emphysema	☐	☐
Bronchitis	☐	☐
Allergies	☐	☐
Tuberculosis	☐	☐
Pneumonia	☐	☐
Sarcoidosis	☐	☐
Lung Disease	☐	☐
Endocrine		
Diabetes	☐	☐
Thyroid Disease	☐	☐
Gastrointestinal		
Bowel Problems	☐	☐
Digestive Problems	☐	☐
Ulcer Disease	☐	☐
Liver Disease	☐	☐
Gallbladder Disease	☐	☐
Pancreatic Disease	☐	☐

Do you use any tobacco products? _____ Do you consume any alcohol products? _____

Describe any previous injuries or surgeries. _____

Has anyone in your FAMILY (blood relatives only) had any of the following medical problems?

Glaucoma Macular Degeneration Eye Disease Arthritis Lupus Diabetes Heart Disease High Blood Pressure

Thyroid Disease Asthma Tuberculosis Sjogren's Syndrome Lung Disease Stroke Cancer Other: _____

Patient / Parent Signature _____ Dr. _____ Date _____