EYE HISTORY

Date of last eye exam_____ Last dilation with drops_____

Do you have any of the following? (check all that apply)

◯ Blurry Vision (distance)	◯ Tearing	◯ Redness	◯ Burning
◯ Blurry Vision (near)	◯ Dry Eyes	◯ Itching	◯ Eye Pain
◯ Difficulty at Computer	◯ Headaches	◯ Floaters	◯ Glaucoma
◯ Light Sensitivity	◯ Double Vision	◯ Cataracts	◯ Macular Degeneration

CONTACT LENS HISTORY

Do you currently wear contact lenses? ◯Yes ◯No If not, are you interested? ◯Yes ◯No

Type (please circle): Soft Hard Toric Multifocal

Brand_____

Prescription R_____ L_____ BC_____ Diameter_____

How Many hours per day do you wear your lenses? _____

How often do you dispose of your lenses? _____

How old is your current pair of lenses? _____

What brand of solution do you use for your lenses? _____

MEDICAL HISTORY

Date of last medical exam _____ **Name of Physician**_____

Do you have any problems with any of the following? (please check all that apply)

◯ Immunologic (multiple sclerosis, lupus)	◯ Cardiovascular (high BP, cholesterol)
◯ Ear / Nose / Throat / Mouth (sinusitis)	◯ Endocrine (diabetes, thyroid)
◯ Gastrointestinal (ulcers, liver)	◯ Neurological (stroke, seizure)
◯ Integumentary (skin disorders)	◯ Respiratory (asthma, breathing)
◯ Genitourinary (prostate, kidney)	◯ Psychological (anxiety, depression)
◯ Musculoskeletal (arthritis)	◯ Cancer (breast, lymphoma)

FAMILY HISTORY - *List Relation*

High Blood Pressure_____ Cataracts_____

Diabetes_____ Retinal Detachment _____

Glaucoma_____ Blindness_____

Macular Degeneration_____ Any other eye condition_____

*Please list **ANY** medications that you are currently taking (prescription, non-prescription, vitamins, supplements)

type of medication (name) _____ _____ _____

_____ _____ _____ _____

*Do you use Tobacco? ◯Yes ◯No *Do you drink alcohol? ◯Yes ◯No

*Do you have any allergies? ◯Yes ◯No If yes, please list _____

To any medications? Please list _____

Patient Signature_____ Date _____