Print Form

Patient Name: _____ **Date:** _____

Personal Eye History:

Reason for visit: _____

Last Eye Exam:_____

Do you wear glasses? (Y / N) ____ ☐ Full time ☐ Distance ☐ Computer ☐ Reading

Do you wear contacts? (Y / N) _____ ☐ Soft ☐ Gas Permeable ☐ Mono-vision ☐ Multifocal

Brand name of contacts_____Name of solution_____

Do you use computers? (Y/ N) _____ How many hours a day?_____Distance from screen(s)_____

Fatigued or sore eyes after using the computer? (Y/ N) _____ Any Head/Neck pain? (Y/ N) _____

Describe the source of lighting in your work area? ☐ Fluorescent ☐ Incandescent ☐ Windows ☐ Other_____

What is your occupation?_____

Do you enjoy any sports/hobbies? _____ Please describe them:_____ _____

Please check any of the following symptoms that you are experiencing:

☐ Blurred vision- Distance
☐ Blurred vision- Near
☐ Crossed eyes
☐ Eye twitching
☐ Double vision
☐ Red eyes
☐ Burning eyes
☐ Watery eyes
☐ Dry eyes
☐ Itchy eyes
☐ Painful/sore eyes
☐ Poor night vision
☐ Light sensitive/Glare
☐ Discharge from eyes
☐ Flashes of light/Floaters

Please check any of the following that you have or had in the past:

☐ Macular Degeneration
☐ Blindness
☐ Glaucoma
☐ Retinal Detachment
☐ Cataracts
☐ Retinal Disease

Eye Injury_____ Eye Surgery Which type?_____Date:_____

Medical History:

Last Physical Exam:_____Physician's Name:_____

Do you have any of the following conditions? (Please Circle any that apply).

☐ Allergies/Hay fever ☐ Cardiovascular(heart) ☐ Ear/Nose/Throat ☐ Endocrine(hormonal)

☐ Gastrointestinal ☐ Genitourinary(kidneys) ☐ Integumentary(skin) ☐ Musculoskeletal (arthritis)

☐ Neurological(seizures) ☐ Psychiatric ☐ Respiratory(lungs) ☐ High Blood Pressure

Diabetes: (Y / N) ____ Date of initial diagnosis:_____ Type: 1 or 2 _____ Last HbA1c:_____ (b/t 4-12)

Medications (include vitamins, eye drops, birth control):_____ _____

_____

Medication allergies? (Y / N) _____ Allergies: _____

Do you use any tobacco products? (Y / N) _____ How many times per day?_____

Family History: Are there any family members with the following conditions? If so, please identify their relation to you.

Macular Degeneration_____Glaucoma_____Cataracts_____
Blindness_____Retinal Detachment_____Retinal Disease_____