

Date: _____

VISION/HEALTH HISTORY

PLEASE PRINT and complete the entire form and bring with you to your eye exam.

| | | | |
|---|--|---|-------------------------|
| Name <small>(Last, First, M.I.):</small> | | Prefer to be called: | Age: |
| Main Reason for visit today: | | Family members who are patients here: | |
| Referred by: | | Family Physician: | |
| What type of work do you do? | | Do you work with a computer ? <input type="checkbox"/> yes <input type="checkbox"/> no | How many hours per day? |
| What sports and hobbies do you enjoy? | | | |

OCULAR HISTORY

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| Date of last eye exam : | Do you wear eyeglasses ? | How old are your glasses? |
| Do you wear contact lenses ? | Type/brand: | Replacement schedule: days week month |
| How many hours per day do you wear your contacts? | How many hours have you worn your contacts today? | |
| Are you interested in wearing contact lenses ? <input type="checkbox"/> yes <input type="checkbox"/> no | | |
| Do you have a history of? (Check all that apply) | | |
| <input type="checkbox"/> Previous eyeglasses | <input type="checkbox"/> Blindness | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Previous contact lens wear | <input type="checkbox"/> Double vision | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Retinal detachment |
| <input type="checkbox"/> Eye injury | <input type="checkbox"/> Eyes crossed or turned out | <input type="checkbox"/> Macular degeneration |
| <input type="checkbox"/> Dry eye | <input type="checkbox"/> Other: | |
| Please give details: | | |
| | | |
| | | |

HEALTH HISTORY

| | | |
|--|--|--|
| Do you have a history of? (Check all that apply) | | |
| <input type="checkbox"/> Allergies / asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Headaches / migraines | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Auto-immune disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Other |
| Please give details and list ANY other medical conditions not listed above: | | |
| | | |
| | | |

List your prescribed and over-the-counter medications, and the condition being treated

| Name of medication | Condition being treated | Name of medication | Condition being treated |
|---------------------------|-------------------------|---------------------------|-------------------------|
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| Are you allergic to any medications? | If yes , please list the medications below: |
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| | |

FAMILY HISTORY

| | | |
|---|---|---|
| Is there a family history of any of the following? (Please check all that apply and indicate relationship to patient) | | |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Strabismus (crossed or wandering eyes) | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Macular degeneration |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blindness | <input type="checkbox"/> Retinal detachment |
| <input type="checkbox"/> Other serious eye condition: | | |