Eye Health History

What prompted your visit?______________________________ Date of last eye exam:____________________
Name of Doctor:______________________

If you wear glasses , please answer the following: ☐ All the time ☐ Reading ☐ Driving ☐ TV ☐ Occasionally

If you wear contact lenses, please answer the following:
Type of contact lenses: ☐ Soft daily wear ☐ Soft extended wear ☐ Disposable ☐ Toric ☐ Gas Permeable
\# of Hours/Day______________ Describe any problems you have with contacts:______________________________
If you do not wear contacts lenses, are you interested? ☐ Yes ☐ No

Do you have any eye problems other than corrective lenses? ☐ None Circle if you currently have (or have had) any of the following:

Bloodshot eyes	Crossed Eyes/Lazy Eye	Double Vision	Light Sensitive/Glare	Sandy/Gritty Feeling
Blurred Vision	Discharge from Eyes	Eye Strain/Tired Eyes	Loss of Vision	Styes or Chalazion
Burning Eyes	Distorted Vision/Halos	Flashes/Floaters	Night Vision, Poor	Twitching Eyelid
Color Vision, Poor	Dizzy Spells	Itching Eyes	Red Eyes	Watering/Tearing

Blindness	self family	Crossed Eyes/ Lazy Eye	self family	Glaucoma	self family	Injury/Scar	self		
Cataracts	self family	Headaches/ Migraines	self family	Dry Eyes	self family	Retinal Disease	self family		

Have you had previous Eye Surgery? ☐ yes ☐ no Explain:____

Health History

Physician's name:______________________ Clinic:____________________ Date of last visit:_______________

Circle YES or NO if you have had any of the following. Also, circle if a family member has had any of the following:

	self	family
BONES/JOINTS/MUSCLES		
Arthritis	yes no	yes no
CANCER (type:___________)	yes no	yes no
CHEMICAL DEPENDECY	yes no	yes no
EARS/NOSE/THROAT		
Allergies	yes no	yes no
Sinusitis	yes no	yes no
ENDOCRI NE		
Diabetes	yes no	yes no
Menopause	yes no	yes no
Thyroid Condition	yes no	yes no
GASTROINTESTINAL		
Crohn's	yes no	yes no
Diarrhea	yes no	yes no
GENITOURINARY		
(genitals/kidney/bladder)	yes no	yes no
HEPATITIS	yes no	yes no
(type: A B C)		
HIV/AIDS	yes no	yes no
INTEGUMENTARY (skin)		
Eczema	yes no	yes no
Lupus	yes no	yes no
Rosacea	yes no	yes no
Sjogrens	yes no	yes no

	self	family
LYMPHATIC		
Anemia	yes no	yes no
Bleeding Problems	yes no	yes no
NEUROLOGICAL		
Epilepsy or Seizures	yes no	yes no
PSYCHIATRY	yes no	yes no
RESPIRATORY		
Asthma	yes no	yes no
Chronic Bronchitis	yes no	yes no
Emphysema	yes no	yes no
Tuberculosis	yes no	yes no
VASCULAR		
Artificial Valves	yes no	yes no
Heart Murmur	yes no	yes no
Heart Pain/Angina	yes no	yes no
High Blood Pressure	yes no	yes no
Stroke	yes no	yes no
MISCELLANEOUS		
Rheumatic Fever	yes no	yes no
Shingles	yes no	yes no
PREGNANT?	yes no	______ months
TOBACCO USE?	yes no	_____/day (amt)
ALCOHOL USE?	yes no	_____/day (amt)

MEDICATIONS

List medications you are currently taking, including eye drops:

Acutane	yes no	Aspirin	yes no	Imitrx	yes no
Anti-anxiety	yes no	Blood Pressure	yes no	Insulin	yes no
Antibiotics	yes no	Contraceptives	yes no	Steroids	yes no
Anti-Coagulants	yes no	Cordarone	yes no	Sulfa Drugs	yes no
Anti-Depressants	yes no	Heart Med	yes no	Tranquilizer	yes no

Others:____
____
____
____

ALLERGIES

List allergies or sensitivities to the following:

☐ Adhesive tape
☐ Betadine
☐ Latex
☐ Steroids

Others: ______________________
____
____
____
____

Patient Name ______________________ Signature______________________ Date ____________