

Patient's Name: _____

Date: _____

MEDICAL HISTORY

MAJOR ILLNESSES - Please place a check mark by any conditions you have now, or have had in the past:

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Seizures (Epilepsy) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Hardening of the Arteries | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Paralysis of Arms or Legs | |

Other: _____

Do you smoke? Yes No How much per day? _____

Do you drink alcohol? Yes No How much per day? _____

SURGERIES - Please list ALL surgeries that you have had, and the approximate dates: _____

MEDICATIONS - Please list ALL medications that you are CURRENTLY taking (including vitamins, hormones, birth control pills, and prescription medications): _____

MEDICATION ALLERGIES - Please list ANY medications to which you've had allergic reaction in the past:

FAMILY HISTORY - Please check any conditions that blood relatives have, or have had:

- | | | |
|---|---|--|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lazy Eye/Amblyopia |
| <input type="checkbox"/> Crossed/Crooked Eyes | <input type="checkbox"/> History of Eye Surgery | <input type="checkbox"/> Retinal Detachment/Degeneration |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems/Stroke | <input type="checkbox"/> Seizures |

PERSONAL EYE HISTORY - Please check any eye conditions or treatments that you have had:

- | | | |
|--|---|--|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Dryness | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Excessive Watering | <input type="checkbox"/> Sensitivity to Light |
| <input type="checkbox"/> Difficulty at night | <input type="checkbox"/> Floaters or Specks | <input type="checkbox"/> Temporary Vision Loss |
| <input type="checkbox"/> Discharge from eye | <input type="checkbox"/> Injury | <input type="checkbox"/> Trouble Reading |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Light Flashes | <input type="checkbox"/> Trouble seeing far away |

Other: _____

Please list any drops or pills you are currently taking for your eyes (with or without a prescription): _____

Have worn glasses for _____ years Current pair of glasses are _____ years old.

Wear glasses for: Reading only Driving only Full-time Date of last exam: _____

Was your prescription for glasses or contacts changed during that exam? Yes No