Patient Name: **Date:**

EYE HISTORY

How can we help you today? -->

(Please list any symptoms to your eyes or vision you are experiencing)

Date of Last Eye Exam:
Name of Last Eye Doctor:
Do you wear Glasses? ☐ yes ☐ no How old are they?
☐ full time ☐ reading only ☐ distance only
Do you wear Contacts? ☐ yes ☐ no
Type: Solution used:
Success with contacts? Not good fair good
Do you use computers? ☐ yes ☐ no
How many hours a day?
How do you use your eyes during the day?

Do you have any hobbies?

Please circle yes or no to indicate if you have/had any of the following:

Bloodshot eyes	Yes	No	Flashes or Floaters	Yes	No
Blurred vision - distance	Yes	No	Glaucoma	Yes	No
Blurred vision - near	Yes	No	Headaches	Yes	No
Burning eyes	Yes	No	Itching eyes	Yes	No
Cataracts	Yes	No	Light sensitive	Yes	No
Color vision - poor	Yes	No	Night Vision poor	Yes	No
Crossed Eyes	Yes	No	Red eyes	Yes	No
Discharge from eyes	Yes	No	Sandy/Gritting Feeling	Yes	No
Double vision	Yes	No	Seeing halos	Yes	No
Dry eyes	Yes	No	Sudden Vision Loss	Yes	No
Eye injury	Yes	No	Twitching Eyelid	Yes	No
Eye surgery	Yes	No	Watery Eyes	Yes	No

MEDICAL HISTORY

Social History (This information is strictly confidential. However you may discuss this portion directly with your doctor, if so, please check box ☐)

Do you use tobacco products? ☐ yes ☐ no
Do you drink alcohol? ☐ yes ☐ no
Do you use illegal drugs? ☐ yes ☐ no
Have you ever been exposed to or infected with: (circle)
gonorrhea hepatitis HIV syphilis

Review of Systems:

Do you have diabetes or pre-diabetes (circle)? ☐ yes ☐ no
Last known fasting blood sugar: _____
Hba1c: _____ (usually between 4-12)
Do you have high blood pressure: ☐ yes ☐ no
Last blood pressure reading: _____ / _____
Do you have high cholesterol: ☐ yes ☐ no
Latest readings: _____

Your Physician's Name:
Phone Number:
Last Physical Date:
Overall health: poor fair good excellent (circle)
Medications: (include vitamins, eye drops, birth control pills)
☐ No Medications

Allergies to Medications or Substances:

Do you have a problem with: (circle all that apply)

Allergic/Immunologic Hay fever, Medicine	Yes	No
Constitutional Symptoms Fever, Weight Loss	Yes	No
Cardiovascular Heart Pain, High Blood Pressure Vascular Disease	Yes	No
Ear, Nose, Mouth Throat Allergies, Hay Fever, Sinus Chronic Cough, Dry mouth Chronic ear infections	Yes	No
Endocrine Diabetes, Thyroid problems Other glands	Yes	No
Gastrointestinal Diarrhea, Constipation, Ulcers	Yes	No
Genitourinary Genitals, Kidneys, Bladder	Yes	No
Hematologic/Lymphatic Anemia, Bleeding Problems Swelling	Yes	No
Integumentary Skin, Breast	Yes	No
Musculoskeletal Arthritis, Rheumatoid Arthritis Joint Pain	Yes	No
Neurological Headaches, Seizures	Yes	No
Psychiatric Nervous Disorders, Depression	Yes	No
Respiratory Asthma, Shortness of Breath, Emphysema, Lung Cancer	Yes	No

Is there anyone in the **family** that has/had:

			Who?
Blindness	Yes	No	
Cataracts	Yes	No	
Corneal Problems	Yes	No	
Diabetes	Yes	No	
High Blood Pressure	Yes	No	
Glaucoma	Yes	No	
Lazy Eye	Yes	No	
Macular Degeneration	Yes	No	
Retinal Problems	Yes	No	
Cancer	Yes	No	
Heart Disease	Yes	No	
Bleeding Disorders	Yes	No	
Multiple Sclerosis	Yes	No	
Other:			

History Reviewed by the Doctor: *Doctor's Signature* X _____ Date: _____