Name (Print)______________________________ Age ________ M / F Date ____________

Reason for Today's Visit: ______________________ Any Special Eye or Vision Problems? ____________

Occupation: ______________________ Hobbies: ______________________

What problems are you having with your **EYES**?	Yes (√)	No (√)	History of Present Symptoms (For Doctor/Staff)	Date of Last Eye Exam ________ Doctor ________
Blurred Vision– Far/ Near/ Middle				Date of Last Physical: ________ Doctor: ________ Phone Number: ________ Next Appt: ________
Sudden Vision Loss				
"Tired Eyes"				
Dryness of the Eye(s)				
Tearing / Redness / Discharge				Pharmacy Name: ________ Phone Number: ________
Itching / Burning / Gritty Feeling				
Eyelid Swelling				Contact Lens Use for ______ years Soft ______ DW ______ Rigid ______ EW ______ Hard ______ Flex ______ Type ________ Age of CLs ________ Comfortable Yes No Solution(s)________ Solution Allergies Yes No
Eye Turn/Crossed Eye/Lazy Eye				
History of Eye Injury / Surgery				
History of Seeing Floaters				
Glaucoma				
Any Other Eye Diseases				
Computer Use			Hours/day: Eye Strain Yes No	
Wear Glasses			**Single Vision** – Distance or Near Vision / **Bifocals / Trifocals / Progressives**	
Allergic to any Medications	Please List:			
Taking any Medications	Please List:			

Today I am Interested in: ☐ Glasses ☐ Sunglasses ☐ Contact Lenses - Clear / Colored ☐ LASIK

Females: Are you pregnant? ☐ Yes ☐ No ☐ Not Sure Are you nursing? ☐ Yes ☐ No

Personal Medical History

Mental Status	Yes	No
Depression	☐	☐
Anxiety	☐	☐
Other: ____________		
Neurology		
Stroke	☐	☐
Seizures	☐	☐
Paralysis	☐	☐
Dizziness	☐	☐
Double Vision	☐	☐
Head		
Ear Problems	☐	☐
Sinus Problems	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Sinus/Allergies	☐	☐
Stress/Tension	☐	☐
w/ Eye Strain	☐	☐

Genitourinary	Yes	No
Kidney Problems	☐	☐
Bladder Problems	☐	☐
Prostate Problems	☐	☐
Cardiovascular		
Heart Disease	☐	☐
Enlarged Heart	☐	☐
Irregular Heart Beat	☐	☐
Shortness of Breath	☐	☐
High Blood Pressure	☐	☐
Hematology		
Anemia	☐	☐
HIV +	☐	☐
Hepatitis _______	☐	☐
Sickle Cell / Trait	☐	☐
Cancer	☐	☐
Muskuloskeletal		
Arthritis	☐	☐
Back Problems	☐	☐
Neck Problems	☐	☐

Pulmonary	Yes	No
Asthma	☐	☐
Emphysema	☐	☐
Bronchitis	☐	☐
Allergies	☐	☐
Tuberculosis	☐	☐
Pneumonia	☐	☐
Sarcoidosis	☐	☐
Lung Disease	☐	☐
Endocrine		
Diabetes	☐	☐
Thyroid Disease	☐	☐
Gastrointestinal		
Bowel Problems	☐	☐
Digestive Problems	☐	☐
Ulcer Disease	☐	☐
Liver Disease	☐	☐
Gallbladder Disease	☐	☐
Pancreatic Disease	☐	☐

Do you use any tobacco products? ________________ Do you consume any alcohol products? ________________

Describe any previous injuries or surgeries. ______________________________

Has anyone in your FAMILY (blood relatives only) had any of the following medical problems?

Glaucoma Macular Degeneration Eye Disease Arthritis Lupus Diabetes Heart Disease High Blood Pressure

Thyroid Disease Asthma Tuberculosis Sjogren's Syndrome Lung Disease Stroke Cancer Other: ____________

Patient / Parent Signature ______________________ Dr. ________________ Date ____________