Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last eye exam? \_\_\_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How old are your glasses? \_\_\_\_\_\_\_\_\_

Have you ever considered contact lenses? \_\_\_ Yes \_\_\_\_\_No

Have you ever considered LASIK (laser vision correction)? \_\_\_Yes \_\_\_No

**Social History:** Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? \_\_\_ Never \_\_\_ Occasionally \_\_\_ Moderate

Do you use tobacco? \_\_\_Never \_\_\_\_Formerly \_\_\_\_Occasionally \_\_\_\_ Daily

**PRESENT EYE CONDITIONS: Mark (X) if you have the following:**

\_\_\_ wear glasses \_\_\_halos around lights \_\_\_redness or inflammation \_\_\_\_double vision

\_\_\_trouble reading \_\_\_flashes of light \_\_\_prior eye injury \_\_\_poor night vision

\_\_\_floating spots \_\_\_lazy eye \_\_\_poor distant vision \_\_\_loss of sight episodes

\_\_\_glaucoma \_\_\_eye pain \_\_\_cataracts \_\_\_stinging or burning

\_\_\_crossed eye as a child \_\_\_tearing/sandy feeling \_\_\_retinal disease or detachment

**MEDICAL HISTORY: Mark (X) If you have had the following:**

\_\_\_diabetes. How long\_\_\_\_\_\_\_\_ \_\_\_cancer. What type\_\_\_\_\_\_\_\_ \_\_\_heart trouble

\_\_\_blood disorders \_\_\_circulation problems \_\_\_high cholesterol

\_\_\_high blood pressure. How long\_\_\_\_\_\_\_\_ \_\_\_ breathing problems (Asthma, COPD)

\_\_\_arthritis. Type\_\_\_\_\_\_\_\_ \_\_\_other major illness. Type\_\_\_\_\_\_\_\_

**FAMILY HISTORY: Mark (X) is if someone in your family has had the following:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Cataract | Glaucoma | MacularDegeneration | Diabetes | High BloodPressure | HeartTrouble | Cancer |
| Mother |  |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |  |
| Sibling |  |  |  |  |  |  |  |
| Grandparent |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

List all medications you are allergic to and what reaction you have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any previous surgeries you have had anywhere on your body: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all mediations you take including prescriptions and over the counter medications (or include list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_