

Date: _____ Date of Birth: _____
 Last Name: _____ First Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Home: _____ Age: _____
 Work: _____ Sex: Male Female
 Cell: _____ Email: _____
 Occupation: _____ Social Security: _____
 Primary Care Physician: _____ Date of last Exam: _____
 Reason for today's Visit: _____

Last Eye Exam

Y / N Do you currently wear glasses? _____
 Y / N Do you wear contact lenses? _____
 How often do you sleep or nap in your contact lenses? _____
 How often do you replace your contact lenses? _____ Solution used: _____
 Lens Brand: _____ Lens Powers: Right Eye _____ Left Eye _____

By Whom: _____

Circle: Distance Reading Progressive

THERE IS A FEE FOR EVALUATION OF YOUR CURRENT CONTACT LENSES

Eye History

Do you currently, or have you ever had problems in any of the following areas?

Y / N Blur at: Distance/Near/Mid-range	Y / N Cataract
Y / N Eyestrain/ Tired eyes	Y / N Glaucoma
Y / N Double Vision	Y / N Macular Degeneration
Y / N Crossed/ Lazy eye	Y / N Retinal Detachment
Y / N Eye Discomfort- circle all that apply	Y / N Flashes of light
Redness	Y / N Floaters in vision
Dryness	Y / N Eye injury
Burning	Y / N Eye surgery _____
Itching	
Watery	
Sandy/Gritty	
Sore	
Painful	
Light sensitive	

General History

Y / N *Women:* Are you pregnant or nursing? _____
 Y / N Are you currently taking medications? If yes, please list all, including Over The Counter medicine.
Medications: _____ **Condition Being Treated:** _____

 Y / N Allergies to medications? _____
 Y / N Do you use tobacco products? If yes, type, amount, how long? _____

Review of Systems

Family History

Vascular/Cardiovascular

Y / N Diabetes
 Y / N High Blood Pressure
 Y / N Vascular disease
 Y / N Cholesterol

Endocrine

Y / N Thyroid

Neurological

Y / N Headaches
 Y / N Migraines
 Y / N Seizures

Psychiatric

Respiratory

Y / N Asthma
 Y / N Chronic Bronchitis
 Y / N Emphysema

Bones/Joints/Muscles

Y / N Rheumatoid Arthritis
 Y / N Muscle pain

Ear/Nose/Throat

Y / N Allergies
 Y / N Sinus problems
 Y / N Dry Mouth

Other

Y / N High Blood Pressure
 Y / N Diabetes
 Y / N Heart Disease
 Y / N Cancer
 Y / N Thyroid
 Y / N Glaucoma
 Y / N Cataracts
 Y / N Macular Degeneration
 Y / N Retinal Disease
 Y / N Blindness

Doctor's Signature: _____

Date: _____