Health History

Patient Name: _____ Date: _____

Current Medications:

_____

_____

_____

_____

Please list all medications you are **allergic** to:

_____

_____

_____

Do you smoke or use tobacco? □ Yes □ No

Current Eye Symptoms (Check all that apply to YOU)

□ Glare sensitivity
□ Tired Eyes
□ Burning
□ Dryness
□ Watery eyes
□ Eye Infection
□ Redness
□ Blurred Distance vision
□ Blurred Near/Reading vision
□ Double Vision
□ Flashes
□ Floaters or spots
□ Eye Injury
□ Other:_____

Eye History (Check all that apply to YOU)

□ Amblyopia / Lazy eye
□ Blindness
□ Cataract
□ Eye surgery – Type: _____
□ Diabetic retinopathy (bleeding)
□ Glaucoma
□ Macular Degeneration
□ Retinal Detachment
□ Other:_____

General Health Conditions (Check all that apply to YOU)

□ Fever
□ Weight loss
□ Ears, Nose, Throat
□ Heart Disease
□ High blood pressure
□ Asthma
□ Emphysema
□ Upper respiratory Infection
□ Gastrointestinal
□ Kidney / Bladder disorder
□ Arthritis
□ Rosacea
□ Frequent Headaches
□ Anxiety
□ Depression
□ Diabetes
□ Thyroid
□ Anemia
□ High Cholesterol
□ Seasonal allergies
□ Cancer – Type: _____
□ Pregnant
□ Nursing
□ Other: _____

Family History (Check any condition that applies to your family (Parents, Grandparents, Siblings, Children; living or deceased)

□ Amblyopia / Lazy Eye
□ Blindness
□ Cataracts
□ Glaucoma
□ Macular Degeneration
□ Retinal Detachment
□ Retinitis Pigmentosa
□ Cancer
□ Diabetes
□ Heart Disease
□ High Blood Pressure
□ Other Eye Condition:_____

Please answer the following questions about yourself:

Occupation: _____ Employer: _____

Interests / hobbies / sports you participate in _____

_____

Do you currently wear contacts? □ Yes □ No

Are you interested in wearing contacts? □ Yes □ No

Are you interested in laser eye surgery? □ Yes □ No

Are you interested in new glasses today? □ Yes □ No