Name _____

Date of Birth _____

Reason For Today's Visit *(including any eye concerns you have)*:_____

Please circle all that apply:

Allergy Eyes	Blurry Vision: Distance, Near, Intermediate	Broken Glasses	Cataract Check
Contact Lenses	Diabetic Eye Exam	Dry Eyes	Glaucoma Check
DMV Report	Flashes of Light	Floaters	Itching Eyes
Lost Glasses	Macular Degeneration Check	Red/Painful Eye(s)	Scratched Glasses
Watery Eyes	Follow up Visit		

Medical History: *(please circle all that apply:)*

General:	Psychological:	Gastrointestinal:	Skin/Integumentary
Developmental Disabilities	Depression	Crohns	Eczema
Cancer_____	ADD	Colitis	Rosacea
Fatigue	Other _____	Ulcer	Psoriasis
Other _____	Anxiety	Other _____	Herpes Simplex/Cold Sores
	Bipolar	Acid Reflux	Other _____
		Celiac	Herpes Zoster/Shingles
Ear, Nose & Throat:	**Cardiovascular:**	**Gyn/Urinary:**	**Endocrine:**
Hearing Loss	Hypertension	Kidney Disease	Diabetes Type 1 Type 2
Sinusitis	Heart Disease	Prostate Disease	Thyroid
Dry Mouth	Vasculitis	STD _____	Hormonal Dysfunction
Laryngitis	Congestive Heart Failure	Other _____	Other_____
Other _____	Other _____	Pregnant (trimester 1 2 3)	
		Nursing	**Hematology/ Lymph:**
		Herpes	Anemia
		Chlamydia	Large Volume Blood Loss
		Menopause	Ulcer
			High Cholesterol
Neurology:	**Respiratory:**	**Muscular/Skeletal:**	Other _____
Multiple Sclerosis	Cigarette Smoker	Arthritis/Osteoarthritis	
Epilepsy	Asthma	Fibromyalgia	**Allergy/ Immunology:**
Cerebral Palsy	Bronchitis	Muscular Dystrophy	Drug Allergies
Tumors _____	Emphysema	Ankylosing Spondylitis	Environmental Allergies
Other _____	COPD	Other _____	Rheumatoid Arthritis
Stroke/CVA	Sleep Apnea	Osteoporosis	Lupus
Migraines	Other _____	Gout	Sjogren's Syndrome
Autism Spectrum Disorder			Other _____

Please List Your Current Medications: *(ask for additional paper if need more room)*

Drug Name:	Dosage:	Taken How Often:	Reason for Taking:

Please List any Allergies to Medications: _____

Please List any Other Allergies (such as Latex, seasonal, etc.): _____

Please Describe any Major Illnesses/Injuries: _____

_____

Eye History	**X**	Explanation: *(How long, treatments received, drops using etc)*
Amblyopia		
Blindness		
Cataracts		
Color Vision Defect		
Diabetic Retinopathy		
Dry Eyes		
Eye Infection		
Eye Injury		
Glaucoma		
Macular Degeneration		
Retinal Detachment		
Strabismus		
Surgery		
Ulcer		
Other		

When was your last **Eye** Exam? _____ Who was your last doctor?_____

Are you using any eye drops? ____yes ____no What kind?_____

Social History:

Do you drive? Yes _____ No _____

Alcohol Use: Yes _____ No _____ If yes, # _____ drinks per day/ week/ month

Tobacco Use: Yes: Some days _____ Everyday _____ Never _____

Former Smoker _____ (For how long? _____ yrs/ mo)

Type: cigarette/ cigar/ pipe/ smokeless/ vape Amount: _____ per day/ week

Recreational Drug Use: Yes _____ No _____ Amount: _____ Type: _____

Please List Your Current Hobbies/Interests:_____

Special Visual Needs for Work or Hobbies: _____

Are you interested in LASIK or refractive surgery? Yes _____ No _____

Are you interested in Contact Lenses? Yes ___ No __ Are you a current wearer? Y N

Family Medical History: *(check all that apply to blood relatives, parents, grandparents, siblings only)*

*Cancer _____	Grandparents: ___	Father: _____	Mother: _____	Siblings: _____
Hypertension _____	Grandparents: ___	Father: _____	Mother: _____	Siblings: _____
Hyperthyroid _____	Grandparents: ___	Father: _____	Mother: _____	Siblings: _____
Hypothyroid _____	Grandparents: ___	Father: _____	Mother: _____	Siblings: _____
Type 1 Diabetes _____	Grandparents: ___	Father: _____	Mother: _____	Siblings: _____
Type 2 Diabetes _____	Grandparents: ___	Father: _____	Mother: _____	Siblings: _____

*If checked yes, what type of cancer: _____

Family Eye History: *(check all that apply to blood relatives, parents, grandparents, siblings only)*

Cataract _____	Grandparents: _____	Father: _____	Mother: _____	Siblings: _____
Macular Degeneration_____	Grandparents: _____	Father: _____	Mother: _____	Siblings: _____
Glaucoma _____	Grandparents: _____	Father: _____	Mother: _____	Siblings: _____
Blindness _____	Grandparents: _____	Father: _____	Mother: _____	Siblings: _____
Keratoconus _____	Grandparents: _____	Father: _____	Mother: _____	Siblings: _____
Other _____	Grandparents: _____	Father: _____	Mother: _____	Siblings: _____

Contact Lens History:

What brand and type of lens are you currently wearing? _____

What power is your current Rx? Right _____ Left _____

How often do you change your lenses? _____

What solution do you use: _____

Do you sleep in your lenses? Yes ____ No ____

If so, how often do you take them out? _____ For how long? _____

How many years have you worn contacts? _____

Are you happy with your current lenses? Yes _____ No _____

Do you have dryness with your current contact lenses? Yes _____ No _____

If there was one thing you could change about your contact lenses, what would it be?

_____