

Patient name: _____ Date of birth: _____

Employer: _____ Occupation/Title: _____

Emergency contact name: _____ Emergency phone: _____

Race: African American American Indian/Alaska Native Asian Caucasian Hawaiian Hispanic

Ethnicity: Hispanic/Latino Not Hispanic or Latino Preferred Language: English Spanish Other

EYE HEALTH HISTORY

What prompted your visit? _____

Date of last eye exam: _____ Name of previous eye doctor: _____

Do you wear glasses? All the time Occasionally Rarely Never

How do you use your glasses? Reading Driving Computer Sports TV

If you do not currently wear contact lenses, are you interested in learning more about them? Yes No

What type of contact lenses do you wear (if any)? Soft daily wear Toric Multifocal Monovision Gas permeable

On average, how many hours/day do you wear your contact lenses? _____

How often do you throw out your contact lenses? Daily Every 2 weeks Every month Other: _____

Do you have any eye problems other than corrective lenses? Check the box if you currently have any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Bloodshot eyes | <input type="checkbox"/> Eye strain/tired eyes | <input type="checkbox"/> Watery eyes |
| <input type="checkbox"/> Burning eyes | <input type="checkbox"/> Floaters/Flashes | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Poor color vision | <input type="checkbox"/> Itching eyes | <input type="checkbox"/> Eye Turn (in or out) |
| <input type="checkbox"/> Eye Turn (in or Out) | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Other: _____ |

Have you ever had surgery on your eyes? No Yes, Type: _____ Date: _____

Do you or any of your family members have any eye diseases?

Blindness Self Family member: _____ Macular degeneration Self Family member: _____

Lazy eye Self Family member: _____ Glaucoma Self Family member: _____

Cataracts Self Family member: _____

HEALTH HISTORY

Primary Care Physician's Name: _____ Date of Last Visit: _____

Clinic Name: _____ Height: _____ Weight: _____

Medications: Please list all medications you are taking (prescribed and over the counter), INCLUDING vitamins and eye drops:

Allergies: Please list all medications you are allergic to:

Please check the box if you or someone in your family has had any of the following:

Self Family

Cardiovascular

- Heart disease
 Elevated cholesterol
 High blood pressure

Constitutional

- Car sickness
 Dizziness

Endocrine

- Diabetes
Last blood sugar reading: _____
Last A1c: _____
 Thyroid disorder
 Pituitary disorder
 Kidney disease

Gastrointestinal

- Cirrhosis
 Colitis
 Hepatitis Type: _____
 Inflammatory bowel syndrome

Genitourinary

- Prostate Cancer
 Syphilis

Self Family

Head/Ears/Nose/Throat

- Headaches
 Sinusitis
 Hearing loss

Hematology/Lymphatic

- Breast carcinoma
 Cavernous sinus thrombosis
 Sickle cell disease
 Temporal arteritis

Integumentary

- Lupus

Immunologic

- AIDS
 Shingles (Herpes Zoster)
 HIV positive
 Lyme disease
 Sjogren's Syndrome

Musculoskeletal

- Arthritis
 Myasthenia gravis

Neurological

- Traumatic brain injury
 Cerebral palsy
 Multiple sclerosis
 Epilepsy/seizures

Self Family

Psychiatric

- Attention disorder
 Alzheimer's disease
 Anxiety
 Depression
 Learning disability

Respiratory

- Asthma
 Emphysema
 Sarcoidosis
 OTHER: _____

Do you use Alcohol?

- Never
 Rarely
 Moderate
 Daily

Do you use tobacco products?

- Never
 Previously: Date quit: _____
 Currently: Packs/day: _____

Are you currently pregnant?

- Yes
 No

Patient/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____