Name:______________________________ Date of Birth:_____________Today's Date:___________

Date of Last Eye Exam:_____________ Location:______________

Date of Last Medical Exam:____________ Primary Care Physician:____________________________

Reason for Today's Exam: ____

Ocular History

Do you wear prescription glasses? □ Yes □ No

If yes, when do you wear them? □ Full-time □ Driving □ Computer
□ Reading □ OTC readers only

Do you wear contact lenses? □ Yes □ No If yes, how old are your current lenses?_________________

Type of contact lenses? □ Rigid □ Soft □Extended wear

Do you sleep in your contact lenses? □ Yes □ No If yes, how often __________

Problems in the following areas?

Glaucoma	□Yes	□No	Eyes burn or sting	□Yes	□No
Cataract	□Yes	□No	Dry eyes	□Yes	□No
Macular degeneration	□Yes	□No	Glare problems	□Yes	□No
Eye pain	□Yes	□No	Light sensitive	□Yes	□No

Any previous eye surgeries, injuries or infections?____

____

____

Do you use any ocular medications or eyedrops?____

____

Medical History

Problems in the following areas?

Constitutional		
Fever, weight loss/gain	□Yes	□No
Skin disease	□Yes	□No
Neurological		
Headaches	□Yes	□No
Migraines	□Yes	□No
Seizures	□Yes	□No
Endocrine		
Diabetes	□Yes	□No
Thyroid Disease	□Yes	□No
Other Gland Disease	□Yes	□No
Ear Nose Mouth Throat		
Allergies/Hayfever	□Yes	□No
Dry Mouth	□Yes	□No
Respiratory		
Asthma	□Yes	□No
Bronchitis	□Yes	□No
Emphysema	□Yes	□No

Cardiovascular/Vascular		
Heart disease	□Yes	□No
High blood Pressure	□Yes	□No
Stomach/Intestinal Disease	□Yes	□No
Kidney Disease	□Yes	□No
Bones/Joints		
Arthritis	□Yes	□No
Joint Pain	□Yes	□No
Lymphatic/Hematologic	□Yes	□N
Anemia	□Yes	□No
Immunological/Allergic		
Lupus	□Yes	□No
AIDS	□Yes	□No
Psychiatric	□Yes	□No

(continued on other side)

Have you ever been diagnosed with cancer? □Yes □No If yes, list type, year diagnosed, past/current treatment:____

List any major surgeries or hospitalizations you have had:________________________

Are you currently pregnant or nursing? □Yes □No
Any known allergies to food, medications or environmental? □Yes □No If yes, please list:__________

Please **list any medications** you currently take. If you answered "**yes**" to any of the above, or have a condition not listed, please explain:____________________________________

Social History

Please list any sports or hobbies in which you participate:________________________
Do you have visual diffculty when driving? □Yes □No If yes, please describe: ______________

Smoking/Tobacco Use: □Current □Past □Never
Amount/day:__________ Number of Years:____________________
Alcohol Use: □Current □Past □Never Drinks/Week:____________________________
Recreational Drug Use: □Current □Past □Never Type:___________________________
Do you currently have, or been previously diagnosed with, any sexually transmitted diseases?
□Yes □No If yes, please specify: □Hepatitis □Gonorrhea □HIV
□Syphilis □Chlamydia □Other:______________________

Family History

Please note any family (blood relation) history and indicate family member:

Disease/Condition	Yes	No	Relation to you	Disease/Condition	Yes	No	Relation to you
Blindness	□	□	__________	Cancer	□	□	__________
Cataract	□	□	__________	Diabetes	□	□	__________
Crossed Eyes	□	□	__________	Heart Disease	□	□	__________
Glaucoma	□	□	__________	Hypertension	□	□	__________
Macular Degen.	□	□	__________	Kidney Disease	□	□	__________
Retinal Detachment	□	□	__________	Lupus	□	□	__________
Arthritis	□	□	__________	Thyroid Disease	□	□	__________

____
Doctor's Signature Date Tech Init.