



## Patient History and Information

### Visual History

What is the main reason for today's exam? \_\_\_\_\_

When was your last exam? \_\_\_\_\_

### Current Medications

Do you have any drug allergies?  Yes  No

If Yes, please describe: \_\_\_\_\_

### Eye History (Circle only those that apply)

Glaucoma	Dryness	Strabismus (Crossed Eyes)
Cataract	Excess Tearing/Watering	Blurred Vision Distance
Macular Degeneration	Eye Pain or Soreness	Blurred Vision Near
Retinal Detachment	Foreign Body Sensation	Distorted Vision (halos)
Color Blindness	Infection of Eye or Lid	Double Vision
Headaches	Itching	Floaters or Spots
Glare/Light Sensitivity	Mucous Discharge	Fluctuating Vision
Tired Eyes	Drooping Eyelid	Loss of Vision
Amblyopia (Lazy Eye)	Redness	Loss of Side Vision
Burning	Sandy or Gritty Feeling	

### General Health Condition (Circle only those that apply)

Fever	Respiratory (Asthma)	Anxiety or Depression
Weight Loss	Gastrointestinal	Endocrine (Thyroid, Diabetes)
Other Symptoms	Kidney	Blood/Lymph
Ears, Nose, Throat	Muscles, Bones, Joints	Allergies
Cardiovascular	High Blood Pressure	

Are you?  Pregnant  Nursing

### Family History (Circle only those that apply)

Amblyopia (Lazy Eye)	Retinal Detachment	High Blood Pressure
Blindness	Strabismus (Eye Turn)	Kidney Disease
Cataract (s)	Arthritis	Lupus
Color Blindness	Cancer	Stroke
Glaucoma	Diabetes	Thyroid Disease
Macular Degeneration	Heart Disease	Others

### Spectacle Lens History

Do you use a computer?  Yes  No

Do you have glare problems?  Yes  No

Do you have problems with night vision?  Yes  No

Do you wear sunglasses?  Yes  No

### Contact Lens History

Have you ever tried to wear contact lenses?  Yes  No

Reason for stopping? \_\_\_\_\_

Do you currently wear contact lenses?  Yes  No Since \_\_\_\_\_

Type and brand of contact lenses \_\_\_\_\_

How many hours/day? \_\_\_\_\_ How many days/week? \_\_\_\_\_

Today's wearing time? \_\_\_\_\_

If not a contact lens wearer, are you interested in trying contact lenses at this time?

Yes  No