New Patient History and Information

DATE:________ ________ **Name:** ______________________________

Visual History

What is the main reason for today's exam?____

____

When was your last exam?____

Current Medications

____

____

Do you have any drug allergies? O Yes O No

If Yes, please describe:____

Eye History (Circle only those that apply)

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

General Health Condition (Circle only those that apply)

Cardiovascular	High Blood Pressure	Anxiety / Depression	Kidney
Respiratory (Asthma)	Cholesterol	Gastrointestinal	Blood / Lymph
Weight Loss	Muscle, Bones, Joints	Ear, Nose, Throat	Fever
Endocrine (Thyroid, Diabetes)	Cancer	Allergies	Other_________________

Are you? O Pregnant O Nursing

Family History (Circle only those that apply)

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

Hobbies (Circle only those that apply)

Hunting	Antique Collecting	Woodworking	Travel
Fishing	Car/Truck Refurbishing	Gardening	Sports
Photography	Reading	Crossword/Puzzles	Crafts
Sewing/Crocheting	Painting/Drawing	Exercise/Weight Lifting	Other________________
Scrapbooking	Stamp/Coin Collecting		

Spectacle Lens History

Do you use a computer?	O Yes O No
Do you have glare problems?	O Yes O No
Do you have problems with night vision?	O Yes O No
Do you wear sunglasses?	O Yes O No

Contact Lens History

Have you ever tried to wear contact lenses? O Yes O No

Reason for stopping?____________________________________

Do you currently wear contact lenses? O Yes O No Since__________________

Type and brand of contact lenses ____

How many hours/day?_____________ How many days/week?__________________

Today's wearing time?_____________ Solutions used? ____________________

Using Rewetting drops? O Yes O No Age of current pair? _____________

Extended Wear (Sleep in CL) O Yes O No How often do you change to a new pair? _____

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

O Yes O No

For Doctors Use Only:
Reviewed Form: ____