CONFIDENTIAL

HEALTH HISTORY

(***Please Print***) Today's Date____/____/____Name_____Age____Birthdate____/____/____

How long since your last eye exam?_____Name of Eye Doctor_____

Who is your medical doctor?_____ □ None

PAST, FAMILY, AND SOCIAL HISTORY

Please check any conditions which apply to **YOURSELF** (PAST) or a **BLOOD RELATIVE** (FAMILY):

PAST (yourself)	**OCULAR:**	Cataract	□ yes □ no	Glaucoma	□ yes □ no
		Macular Degeneration	□ yes □ no	Eye Surgery	□ yes □ no
	MEDICAL:	High Blood Pressure	□ yes □ no	Diabetes	□ yes □ no
FAMILY (a relative)	**OCULAR:**	Cataract	□ yes □ no	Glaucoma	□ yes □ no
		Macular Degeneration	□ yes □ no		
	MEDICAL:	High Blood Pressure	□ yes □ no	Diabetes	□ yes □ no

SOCIAL/OCCUPATIONAL: *(This information is kept strictly confidential).*

Do you drive? □ no □ yes If "yes", do you have visual difficulty when driving? □ no □ yes If "yes", please describe:

□ blurred distance vision (signs, etc.) □ blurred vision at night □ glare at night □ dashboard is blurred □ other_____

Do you use tobacco products? □ yes □ no Do you drink alcohol? □ yes □ no Do you use illegal drugs? □ yes □ n

Have you ever been diagnosed with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ Chlamydia □**NONE**

Do you have any special visual needs? If yes, please explain_____

MEDICATION SUMMARY:

Are you regulary taking any medications? □ no □ yes If "yes", please list. Include aspirin, oral contraceptives, over th

counter medications, home remedies, or eyedrops. If you do not know the name of the medication, please list the condition

disease the medication is treating: 1._____, 2._____, 3._____

4._____, 5._____, 6._____, 7._____

REVIEW OF SYSTEMS (EYES)

Check the conditions that apply □ **NONE**

□ Eye Pain/Soreness	□ Dryness	□ Spots/Floaters	□ Stye/Chalazion
□ Redness	□ Sticky/Discharge	□ Flashes	□ Light Sensitivity
□ Burning	□ Strain/Tired	□ Glare	□ Distorted Vision
□ Itching	□ Twitching Eyelic	□ Double Vision	□ Irritation/Sandy or Gritty feeling
□ Watering	□ Eye Injury	□ Drooping Eyelic	□ Loss of peripheral (side) visior
□ Cataracts	□ "Lazy" Eye	□ Eye Infection	□ Poor Color Vision
□ Glaucoma	□ "Crossed" Eye	□ Eye Injury	□ Eye Allergies
□ Macular Degen.	□ Blindness	□ Eye Disease	□ Other_____
□ Retin. Prob./Detach.	□ Dry Eyes	□ Eye Surgery Date/Surgeon(s):	

TURN OVER AND COMPLETE OTHER SIDE

REVIEW OF SYSTEMS (CON'T)

Allergic/Immunologic □ None
- □ drug allergy
- □ environmental allergy
- □ rheumatoid arthritis
- □ lupus
- □ other
- □ meds

Cardiovascular □ None
- □ heart disease
- □ hypertension
- □ stroke
- □ vascular disease
- □ other
- □ meds

Respiratory □ None
- □ cigarette smoker
- □ asthma
- □ bronchitis
- □ emphysema
- □ other
- □ meds

Endocrine □ None
- □ non-insulin dependent diabetes
- □ insulin-dependen diabetes
- □ thyroid dysfunctior
- □ hormonal dysfunctior
- □ other
- □ meds

Ears, Nose, Mouth & Throat □ None
- □ Upper Resp. Tract Infect
- □ other
- □ meds

Gastrointestinal □ None
- □ Crohn's
- □ colitis
- □ ulcer
- □ digestive
- □ other
- □ meds

Genitourinary □ None
- □ STD - viral herpetic, chlamydia
- □ other
- □ meds

Integumentary □ None
- □ eczema
- □ rosacea
- □ psoriasis
- □ other
- □ meds

Muskuloskeletal □ None
- □ fibromyalgia
- □ muscular dystrophy
- □ osteoarthritis
- □ ankylosing spondylitis
- □ other
- □ meds

Neurological □ None
- □ multiple sclerosis
- □ epilepsy
- □ other
- □ meds

Psychiatric □ None
- □ depression
- □ panic disorder
- □ schizophrenia
- □ other
- □ meds

Constitutional □ None
- □ developmental disability
- □ weight loss
- □ fever
- □ fatigue
- □ trauma
- □ other
- □ meds

STAFF USE ONLY

Reviewed _____/_____/_____

Initials_____

CURRENT VISION

Which types of vision correction are you interested in: □ glasses □ contact lenses □ laser vision correction □ non-surgical

Check any that apply: □ Never had prescription glasses □ Lost/Broke/Discontinued □ Glasses only
□ Contact Lenses/No Glasses □ Contact Lenses and Glasses

Current glasses are: □ Single Vision □ Bifocals □ Trifocals □ "Invisible Bifocals" □ Other

Without lenses: Distance: □ clear □ not clear □ not sure Near: □ clear □ not clear □ not sure
With current glasses: Distance: □ clear □ not clear □ not sure Near: □ clear □ not clear □ not sure
I wear my glasses: □ distance only □ near only □ all the time □ computer □ other_____

Previous contact lens wearer? □ yes □ no If "no", interested in wearing contact lenses? □ yes □ no
If previous contact lens wearer, when: □ currently using contact lenses □ less than a year ago □ more than a year ago

With contact lenses: Distance: □ clear □ not clear □ not sure Near: □ clear □ not clear □ not sure
Contact lens comfort: □ good □ OK □ poor (□ dry □ irritation □ "film" □ other_____)
Wear contact lenses: □ all the time □ part time □ other_____

Current lenses: Soft: □ conventional □ disposable □ toric □ bifocal □ monovision □ clear □ colored
Rigid Gas Permeable: □ conventional □ toric □ bifocal □ monovisior
Brand/Power/Base Curve, if known:_____

I remove my lenses every night (daily wear) □ yes □ no **IF "NO":** I sleep in my lenses_____days in a row on average

I replace my lenses every: □ day □ week □ 2 weeks □ month □ year □ other_____