

# EYE HISTORY SHEET



Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

OHIP #: \_\_\_\_\_ Other Health Plan Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ City: \_\_\_\_\_ Optometrist: \_\_\_\_\_

**Do you wear glasses?** Yes / No      **Do you wear contact lenses?** Yes / No

**Do you have problems:**      a) **reading?** Yes / No      b) **driving?** Yes / No

**Do you have any eye problems right now?** Please circle all that apply.

Eye Pain      Blurred Vision      Eyelid Crusting      Flashes/Floaters      Haloes  
Discharge      Light Sensitivity      Double Vision      Decreased Vision      Tearing

**Have you ever had an eye injury?** Please describe. \_\_\_\_\_

**Have you ever had eye surgery?** Please list eye surgery and dates.

\_\_\_\_\_

**Are you using any eye medications?** Please list the medications, which eye(s) and how often used.

\_\_\_\_\_

\_\_\_\_\_

**Do you have any medical conditions?** Please circle all that apply.

Diabetes      Asthma      High Blood Pressure      Heart Disease      Stroke      Arthritis  
Multiple Sclerosis      Migraines      Prostate Disease      Other: \_\_\_\_\_

**Please list all medications you are taking** (other than eye drops).

\_\_\_\_\_

\_\_\_\_\_

**Do you smoke?** Yes / No

**List the medications to which you are allergic.** \_\_\_\_\_

**Do you have a family history of eye problems?** Please circle any that apply.

Lazy/Crossed Eyes      Glaucoma      Cataracts      Macular Degeneration