NAME ______________________________ **DATE** ______________

What is the main reason for today's visit?______________________________

When was your last comprehensive eye exam?____________________

When was your last physical exam (including bloodwork)?______________

SPECTACLE LENS

Do you currently wear glasses?

☐ No

☐ Yes, since:_________ ☐ Full Time ☐ Distance ☐ Computer

☐ Part Time ☐ Close

Glasses owned: ☐ Single Vision ☐ Back-up Glasses

☐ Bifocals ☐ Safety Glasses

☐ Trifocals ☐ Sports Glasses

☐ Progressive

Have you had trouble in the past with glasses?______________________________

Do you wear sunglasses? ☐ No ☐ Yes, are they your current prescription? ☐ No ☐ Yes

CONTACT LENS

Have you ever tried to wear contact lenses? ☐ No ☐ Yes, reason for stopping:____________

Do you currently wear contact lenses?

☐ No

Are you interested in trying contact lenses at this time? ☐ No ☐ Yes

☐ Yes, since:_________

Type/brand of contact lenses:______________________________

Hours/day:_________Days/week:__________Today's wearing time:_________

Please rate the following on a scale of 1 to 10: *(1 = poor, 10 = excellent)*

Lens comfort Right___Left___

Distance Vision Right___Left___

Near Vision Right___Left___

What contact lens solutions do you use? ☐ Cleaner:__________________

☐ Disinfectant:________________

☐ Enzyme:__________________

SOCIAL

Do you use nutritional supplements? ☐ No ☐ Yes

Do you engage in regular exercise? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes, how much/often:____________________

Do you smoke? ☐ No ☐ Yes, how much/often:____________________

MEDICAL HISTORY

EYE HISTORY

- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Color Blindness

- ☐ Headaches
- ☐ Glare/Light Sensitivity
- ☐ Tired Eyes
- ☐ Amblyopia (lazy eye)
- ☐ Burning
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Pain or Soreness
- ☐ Infection of Eye or Lid (stye)
- ☐ Itching
- ☐ Mucous Discharge
- ☐ Drooping Eyelid
- ☐ Redness
- ☐ Sandy or Gritty Feeling
- ☐ Strabismus (eye turn)

- ☐ Blurred Vision Distance
- ☐ Blurred Vision Near
- ☐ Distorted Vision (halos)
- ☐ Double Vision
- ☐ Floaters or Spots
- ☐ Fluctuating Vision
- ☐ Loss of Vision
- ☐ Loss of Side Vision

GENERAL HEALTH

- ☐ Fever
- ☐ Weight Loss
- ☐ Ears, Nose, Throat
- ☐ Cardiovascular (high blood pressure)
- ☐ Respiratory (asthma, emphysema)
- ☐ Gastrointestinal
- ☐ Kidney, Bladder
- ☐ Muscles, Bones, Joints (arthritis)
- ☐ Skin (acne, skin cancer, etc.)
- ☐ Neurological (multiple sclerosis)
- ☐ Psychiatric (depression, insomnia)
- ☐ Endocrine (diabetes, thyroid)
- ☐ Blood/Lymph (cholesterol, anemia)
- ☐ Allergic/Immunologic
- ☐ Infections (hepatitis, HIV, shingles, etc.)

FAMILY HISTORY

- ☐ Amblyopia (lazy eye)
- ☐ Blindness
- ☐ Cataract
- ☐ Color Blindness
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Strabismus (eye turn)

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Stroke
- ☐ Thyroid Disease

Past Illnesses or Injuries:______________________________

Current Medications:______________________________

____

Past Surgeries:______________________________

Medicines that cause reactions/sensitivities:______________________________

Other Allergies:______________________________

Thank you for taking the time to help our office personalize your eyecare. Your answers will help guide our doctors and staff to your specific needs. We look forward to seeing you for your examination. Please feel free to let us know if you have any other concerns we have not addressed.