

MEDICATIONS	ALLERGIES
List medications your are currently taking, including eye drops _____ _____ _____ _____	List your allergies to medications or other substances _____ _____ _____ _____

EYE HEALTH HISTORY
Date of last eye exam? _____ Do you wear glasses? YES or NO Do you wear contact lenses? YES or NO
Type of contacts _____ Any problems with contacts? _____
List any Eye injuries or Surgeries _____

Please mark if you have any of the following symptoms?

<input type="checkbox"/> Blurred Vision – Distance	<input type="checkbox"/> Light Sensitive	<input type="checkbox"/> Double vision	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Blurred Vision – Near	<input type="checkbox"/> Headaches	<input type="checkbox"/> Seeing Flashes or Floaters	_____
<input type="checkbox"/> Burning eyes	<input type="checkbox"/> Glare	<input type="checkbox"/> Watery eyes	_____
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Discharge from eyes	<input type="checkbox"/> Poor night vision	
<input type="checkbox"/> Itching eyes	<input type="checkbox"/> Red eyes	<input type="checkbox"/> Twitching eyelids	

HEALTH HISTORY
Physician's Name _____ Date of Last Visit _____

Please check the boxes next to any conditions that you or any of your blood relatives have been diagnosed with.

	Yourself	Family Members		Yourself	Family Members
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (Type _____)	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Poor Color Vision	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>			

Are You Pregnant? _____ Number of Children _____ Tobacco Use _____
Drug Use _____ Alcohol Use _____

VISUAL DEMANDS:
Circle all activities in which you participate:
Bookkeeping, Camping, Carpentry, Computers, Crocheting, Cross Stitch, Desk work, Farming, Fishing, Flying, Gardening, Golf,
Hunting, Knitting, Mechanics, Music, Reading, Sewing, Sports, Student, Teacher

Reviewed: _____
