Name: _____ Date: _____

OCULAR HISTORY

Date of last eye exam _____

Name of doctor _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving ☐ T.V.

Do you use a computer? ☐ Yes ☐ No ___ hrs./day

Please list hobbies or work with special visual reqirements:

_____

Do you wear contacts? ☐ Yes ☐ No

Type: _____ Hours/day: _____

Are you interested in wearing contacts?

☐ Yes ☐ No ☐ Maybe

Are you interested in information about refractive surgery? ☐ Yes ☐ No

Please check the conditions you have now or have had in the past.

☐ Blurred vision
- ☐ Distance ☐ Near
- ☐ With glasses ☐ Without glasses

☐ Burning eyes
☐ Double vision
☐ Dry eyes
☐ Eye injury
☐ Eye pain
☐ Eye strain
☐ Eye surgery
☐ Flashes of light
☐ Haloes
☐ Headaches
☐ Head injury
☐ Itching eyes
☐ Light sensitivity
☐ Poor color vision
☐ Spots or floaters
☐ Twitching eyelid
☐ Watering eyes
☐ Other _____

_____

_____

MEDICAL HISTORY

Who is your primary care physician? _____ Date of last visit: _____

Physician's address: _____

Please place a check to indicate if you have had any of the following. Also indicate if a blood relative has had any of the following:

	Yourself	Family Member
AIDS/HIV	☐	☐ _____
Allergies	☐	☐ _____
Arthritis	☐	☐ _____
Blood disorder	☐	☐ _____
Cancer	☐	☐ _____
Chemical dependency	☐	☐ _____
Connective tissue disorder	☐	☐ _____
Diabetes	☐	☐ _____
Digestive system disorder	☐	☐ _____
Epilepsy	☐	☐ _____
Heart condition	☐	☐ _____
Hepatitis (Type__)	☐	☐ _____
High blood cholesterol	☐	☐ _____
High blood pressure	☐	☐ _____
Kidney disease	☐	☐ _____
Lung condition	☐	☐ _____
Lupus	☐	☐ _____

	Yourself	Family Member
Migraine Headaches	☐	☐ _____
Neurological disorder	☐	☐ _____
Sinus condition	☐	☐ _____
Skin disorder	☐	☐ _____
Stroke	☐	☐ _____
Thyroid disorder	☐	☐ _____
Tuberculosis	☐	☐ _____
Cataracts	☐	☐ _____
Glaucoma	☐	☐ _____
Macular degeneration	☐	☐ _____

Tobacco Use: _____ Alcohol Use: _____

Women: Are you pregnant? _____

List other significant health history: _____

_____

_____

_____

MEDICATIONS

Please list all prescription medications you are currently taking:

_____

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No (please list):

_____

Please list all non-prescription medications you are currently taking: _____

_____

_____

Do you use any eye drops? ☐ Yes ☐ No (Please list):

_____

I have completed this form to the best of my knowledge. (Initial) _____.