Name:_____ **Date:**_____

***PLEASE DESCRIBE THE MAIN REASON FOR YOUR VISIT TODAY*:**

_____

Eye concerns: (circle if applicable) Blur / Burning / Discharge / Double vision / Dryness / Pain / Strain / Floaters / Light sensitivity / Tearing / Other: _____

Which side is affected: (circle if applicable) Right Left Both None

What is the severity? (circle if applicable) Mild Moderate Severe **How long**? _____

Date of Last Eye Exam:_____

Previous eye doctor: _____

Have you had your eyes dilated in the past? □No □ Yes If yes, when? _____

Do you currently have glasses? □ No □ Yes: How old are they? _____

Are your glasses for: □ Far □ Reading □ Far and near □ Other: _____

Do you currently wear contact lenses? □ No □ Yes Brand of lenses _____

Do you notice any problems with your contacts?_____ Hours worn per day?_____

Age of current pair you are wearing? _____ How often do you replace your lenses? _____

What contact lens solutions, cleaners and drops do you use? _____

Please check the appropriate box if you have or ever had any of the following conditions:

General Health:	Ear, Nose & Throat	Neurological	Psychiatric	Cardiovascular	Respiratory	Gastro-intestinal
□ **NONE**	□ **NONE**	□ **NONE**	□ **NONE**	□ **NONE**	□ **NONE**	□ **NONE**
☐ Fatigue Syndrome	□ Hearing loss	□ Multiple sclerosis	□ Attention Deficit	□ High blood pressure	□ Asthma	□ Colitis
☐ Cancer	□ Dry mouth	□ Epilepsy	□ Anxiety	□ Heart disease	□ COPD	□ Crohn's disease
☐ Developmentally disabled	□ Other:	□ Cerebral palsy	□ Other:	□ Stroke	□ Other:	□ Other:
☐ Other:		□ Tumor		□ Vascular disease		
		□ Stroke		□ Other:		
		□ Migraine				
		☐ Other:				

Name:_____ **Date:**_____

Please check the appropriate box if you have or ever had any of the following conditions:

Genital-Urinary

- □ **NONE**
- □ Kidney disease
- □ Herpes
- □ Chlamydia
- □ Pregnant
- □ Nursing
- □ Other:

Muscle-Skeletal

- □ **NONE**
- □ Arthritis
- □ Fibromyalgia
- □ Muscular dystrophy
- □ Ankylosing spondylitis
- □ Other:

Skin

- □ **NONE**
- □ Eczema
- □ Rosacea
- □ Psoriasis
- □ Cold sores
- □ Shingles
- □ Other:

Endocrine

- □ **NONE**
- □ Diabetes: **insulin-dependent (Type 1)**
- □ Diabetes: **non-insulin dependent (Type 2)**
- □ Thyroid
- □ Hormonal
- □ Other:

Hematologic-Lymphatic

- □ **NONE**
- □ Blood loss
- □ High cholesterol
- □ Tuberculosis
- □ Liver disease
- □ Other:

Allergy-Immune

- □ **NONE**
- □ Drug allergies
- □ Environmental
- □ Rheumatoid arthritis
- □ Lupus
- □ Sjogren's Syndrome
- □ Other:

Please list all your CURRENT MEDICATIONS

● If you have a list, you may present it instead of listing

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medication allergies:

- □ NONE
- □ YES (Please list names and reactions):

SOCIAL HISTORY (circle all that apply)

Non-prescription drug use: Yes No

Alcohol use: None / Occasional / Frequent

Smoking status: Never / Former / Occasional / Frequent

Other allergies (please list):

Latex allergy (circle): No Yes

FAMILY HISTORY (PUT A CHECK IN THE BOX FOR ALL THAT APPLY)

	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER
CANCER						
DIABETES: TYPE 1 INSULIN DEPENDENT						
DIABETES: TYPE 2 NON- INSULIN DEPENDENT						
HIGH BLOOD PRESSURE						
CATARACT						
MACULAR DEGENERATION						
GLAUCOMA						

PAST OCULAR HISTORY (circle all that apply):

NONE

Glaucoma **Glaucoma Suspect** **Cataract**
Dry Eye **Nystagmus** **Keratoconus**

Eye Surgery:_____

Patching **Iritis** **Strabismus** **Amblyopia**
Macular Degeneration **Retinal degeneration**

Retinal hole **Retinal detachment** **Keratoconus**

Injury :_____

Other:_____