Name:_____ Date:_____

PAST OCULAR HISTORY:

When was your last eye examination?_____ By Whom?_____
Do you wear Glasses now? ☐YES ☐NO If so, what kind? ☐Single vision ☐No Line ☐Bifocals ☐Trifocals
Do you wear Contact Lenses? ☐YES ☐NO If so, what kind? ☐Hard ☐Soft ☐Daily Wear ☐Extended Wear
How do you wear your prescription? ☐ Full time ☐Not at all ☐Part-time-When?_____
How old is your current prescription?_____
Have you ever had any eye injuries? ☐YES ☐NO If so, what?_____
Have you ever had any eye surgeries? ☐YES ☐NO If so, what and when?_____
Have you ever been diagnosed with any of the following eye diseases or conditions? ☐Glaucoma ☐Cataracts
☐Lazy Eye ☐Crossed Eyes ☐Macular Degeneration ☐Retinal Detachment ☐Diabetic Retinopathy
☐Other_____
Are you taking any medications for your eyes? ☐YES ☐NO If so what?_____

PAST MEDICAL HISTORY:

Family Doctor:_____Address:_____Last Visit:_____
Do you take any medications, either prescription or over the counter (including vitamins)? ☐YES ☐NO If so, what?
☐ See attached list _____
_____
_____
Do you have any allergies to medications? ☐YES ☐NO If so, what and describe the reaction:_____
_____
Have you ever had any surgeries? (Not Eyes) ☐YES ☐NO If so, what?_____
_____
Please mark and of the following medical conditions you may have or have had in the past:

☐Rheumatic fever	☐Kidney disease	☐Mental illness (nerves)
☐High blood pressure	☐Urinary tract infections	☐Recent weight changes
☐High cholesterol	☐STD's / venereal diseases	☐Fever / night sweats
☐Heart attack / heart failure	☐Arthritis / joint pain	☐Malignancies / cancer
☐Irreg. heart rhythm / heart murmur	☐Skin disease / excessive bruising	☐Bloody nose / nasal drainage
☐Chest pain	☐Breast disease	☐Sore throat
☐Asthma / emphysema / bronchitis	☐Stroke	☐Ear disease
☐Chronic cough	☐Seizures	☐Anemia
☐Tuberculosis exposure	☐Headaches	☐Excessive bleeding
☐Bowel disease	☐Dizziness / light-headed	☐Environmental allergies
☐Ulcers	☐Diabetes-How long?_____	☐Hay fever
☐Constipation / diarrhea	☐Thyroid disease	☐Other medical problems

SOCIAL HISTORY:

Do you use tobacco products? ☐YES ☐NO If so, what and how much?_____
Do you drink alcohol products: ☐YES ☐NO If so, what, how much and how often?_____
Please list any special visual requirements you may have for your job or hobbies?_____

FAMILY HISTORY:

Please mark any of the following medical conditions any of your immediate "blood" relatives have / had:
(ex: Siblings, Parents, Aunts, Uncles, Grandparents)

☐Glaucoma	☐Macular degeneration	☐Heart disease	
☐Cataracts	☐Crossed eyes/ lazy eye	☐Diabetes	
☐Retinal detachment	☐Blindness	☐High blood pressure	☐Cancer

(Please don't initial below if filling out for the first time. Only initial if you are reviewing)

History reviewed by patient. Initials:_____ Date:_____

History reviewed by patient. Initials:_____ Date:_____