

Ocular & Medical History:

Patient Name _____ Age _____ Date _____

Do you wear glasses? Yes No How old is your prescription? _____

Do you wear contacts? Yes No Type? soft gas permeable Cleaning System _____

Do you currently or have you ever had any problems in the following areas:

Please list any medications and/or important details related to the problem in the space below

Ocular	Yes	No	?	
Eyes: Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred/distorted vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy/gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching or Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/ Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyelid infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes or floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Is there a history of any eye problems in **your family** more serious than glasses? If yes, please explain. _____

What is the name of your family/medical doctor? _____ Last medical exam: _____

List all major surgeries, and/or hospitalizations _____

Do you have any allergies to medications? Yes No If yes, explain: _____

Are you pregnant and/or nursing? Yes No

~ TURN OVER ~

Medical History:

Do you currently or have you ever had any problems in the following areas:

Please list any medications and/or important details related to the problem in the space below

CIRCLE CONDITION & CHECK→ Yes No ?

VASCULAR / CARDIOVASCULAR

High Blood Pressure Yes No ? _____

Heart/Cholesterol Yes No ? _____

RESPIRATORY

Asthma/ Emphysema Yes No ? _____

Chronic Bronchitis/COPD Yes No ? _____

BONES / JOINTS / MUSCLES

Rheumatoid Arthritis Yes No ? _____

Osteoarthritis (age related) Yes No ? _____

Joint/Muscle Pain Yes No ? _____

Osteoporosis Yes No ? _____

EARS / NOSE / MOUTH / THROAT

Hay Fever/Allergies/Sinus Yes No ? _____

Dry Throat/Mouth Yes No ? _____

GENITOURINARY

Genitals/ Kidney/Bladder Yes No ? _____

LYMPHATIC / HEMATOLOGIC

Anemia/Bleeding Yes No ? _____

NEUROLOGICAL

Headaches/Migraines Yes No ? _____

Seizures/Psychiatric Yes No ? _____

ENDOCRINE

Diabetes Yes No ? _____

Thyroid/Other Glands Yes No ? _____

DERMATOLOGIC (Skin) Yes No ? _____

Please list any other medications, vitamins, or herbal supplements not listed above: _____

Please list any other health concerns/problems you have not addressed above: _____

Social History:

Occupation _____ Hobbies _____

The following information is strictly confidential. You may discuss this portion directly with the doctor if you prefer.

Do you smoke? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you use recreational/illegal drugs? no yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: HIV Syphilis Gonorrhea Hepatitis (X if yes)

DOCTOR USE ONLY:

Doctor's Signature

Date

Tobacco Cessation Education Given