Health History

Eye History

Reason for Today's Visit:
Date of Last Eye Exam
Do you currently wear glasses? Yes No
Do you currently wear contacts? Yes No
Have you or an immediate family member experienced, or been treated for any of the following? (please indicate who)
Amblyopia (Lazy Eye) No Self Family
Cataracts No Self Family
Crossed Eyes No Self Family
Glaucoma No Self Family
Macular Degeneration No Self Family
Retinal Detachment No Self Family
LASIK / PRK or RK No Self Family
Are you currently experiencing, or have experienced, any of the following? (Check all that apply and explain)
☐ Blurred Vision near or far
☐ Burning
☐ Discharge
☐ Double Vision
☐ Dryness
☐ Eye Infection
☐ Eye Pain / Soreness
☐ Floaters / Spots
☐ Flashes of Light
☐ Halos
☐ Headaches
☐ Itching
☐ Light Sensitivity
☐ Redness
☐ Sandy / Gritty sensation
☐ Watering / Excessive Tearing
Height Weight

Medical History

Have you or an immediate family member experienced, or been treated for any of the following? (indicate relationship)
AIDS / HIV Yes No
Sexually Transmitted Diseases Yes No
Allergies No Self Family
Arthritis (osteo or rheumatoid) No Self Family
Asthma No Self Family
Blood / Lymph Disorder No Self Family
Cancer (Type ________________) No Self Family
Diabetes (Type ________________) No Self Family
Ear, Nose, Throat Conditions No Self Family
Gastrointestinal Conditions No Self Family
Heart Disease No Self Family
High Blood Pressure No Self Family
High Cholesterol No Self Family
Kidney Disease No Self Family
Lupus No Self Family
Neurological conditions No Self Family
Psychiatric Disorder No Self Family
Seizures No Self Family
Skin Conditions No Self Family
Stroke No Self Family
Thyroid Dysfunction No Self Family
Surgeries Yes No (Type ______________________)
Last Tetnus booster
Current Medications (prescription and/or over-the-counter. Dosage)
Medication Allergies
Are you pregnant or nursing? Y N
Do you use tobacco? Y N How much? How Long?
Have you ever smoked? Y N How long ago?
Alcohol? Y N How much? Illegal Drugs? Y N

I have answered all questions to the best of my abilities. Signed ____________________ Date____________