

Patient Name: _____ Date: _____

What are your goals for today's visit? _____
Circle: New glasses New contacts

When was your last exam? _____

Do you wear Eyeglasses? Full time Part time Distance Near Computer Multifocal Sun

Do you wear Contact Lenses? Soft Hard/RGP Full time Part Time

Are you experiencing any of the following symptoms? Blurred vision: Distance Near Intermediate/Computer
Burning Itching Discharge Dryness Watery Eyes/Tearing Redness Flashes
Floaters Eyestrain Headaches Double Vision Pain Hard to see in dim light/poor night vision Glare
Other: _____

Do you have any of the following Eye Conditions: Amblyopia/lazy eye Strabismus/eyeturn Glaucoma
Cataract Macular Degeneration Dry Eye Other: _____

Please list any eye injuries you have had: _____

Please list any eye surgeries you have had: _____

Do you have any of the following medical problems?

| | | |
|--|----------------------|---------------------------|
| Allergies | Hypertension | Shingles |
| Arthritis | High Cholesterol | Skin Disorder |
| Asthma | Kidney disorder | Tuberculosis |
| Cancer (type _____) | Lupus | Thyroid Disorder High Low |
| Diabetes (type _____) (last A1C _____) | Migraines | Sinus Problems |
| Depression | Prostate Disease | Sleep Apnea |
| Heart Disease | Psychiatric Disorder | Spinal Disorder |

Other Medical Problems: _____

Do you use tobacco products now? Yes No

List all medications you are take on a regular basis, including over the counter: (Or give us a copy of your med list)

| Medication | Strength | How Often? | What for? |
|------------|----------|------------|-----------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Do you have any medication allergies? _____ Other Allergies? _____

Does anyone in your family have:

| | | |
|-----------------------|------|-------|
| Glaucoma: | Who? | _____ |
| Cataract: | Who? | _____ |
| Macular degeneration: | Who? | _____ |
| Hypertension: | Who? | _____ |
| Diabetes: | Who? | _____ |

Other eye or medical disorders run in your family?: _____