

# PATIENT HISTORY

**Please check all that apply:**

**Do you ever experience any of the following:**

- |  |                                  |  |   |                                |
|--|----------------------------------|--|---|--------------------------------|
| <input type="checkbox"/> Blurred vision-distance | <input type="checkbox"/> Itching | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Dryness                  | <input type="checkbox"/> Pain  |
| <input type="checkbox"/> Blurred vision-near     | <input type="checkbox"/> Tearing | <input type="checkbox"/> Flashing lights | <input type="checkbox"/> Light sensitive          | <input type="checkbox"/> Glare |
| <input type="checkbox"/> Fluctuating vision      | <input type="checkbox"/> Burning | <input type="checkbox"/> Floating Spots  | <input type="checkbox"/> Temporary loss of vision |                                |
| <input type="checkbox"/> Double Vision           | <input type="checkbox"/> Redness | <input type="checkbox"/> Eye Strain      | <input type="checkbox"/> Eye Injury               |                                |

Other: \_\_\_\_\_

**Have you ever been diagnosed with any of the following EYE CONDITIONS:**

- Glaucoma     Cataract     Macular Degeneration     Retina condition     Keratoconus

Other: \_\_\_\_\_

**Have you ever had any EYE SURGERY for the following:**

- Eyeturn/Muscle     Retina     Cataract     Glaucoma     Cornea  
 Vision Correction – PRK, LASIK, RK, AK, ALK

Comments: \_\_\_\_\_

**Contact Lens History:**

- None     Soft Daily Wear     Soft Overnight Wear     Soft Toric     Hard/RGP/PMMA

Number of years: \_\_\_\_\_ Contact Lens Last Used: \_\_\_\_\_

Difficulty with CL Wear: Yes    No    End of day discomfort with CL Wear: Yes    No

Comments: \_\_\_\_\_

**Eyeglass History:**

- None     Reading     Distance     Progressive     Bifocals    Number of Years: \_\_\_\_\_

**Medical Information:**

Allergies:     None    List: \_\_\_\_\_

Medications:     None    List: \_\_\_\_\_

**General Health Conditions:**

- Diabetes     Migraine     Cholesterol     Shingles     Thyroid  
 Lung Condition     High Blood Pressure     Cancer     Arthritis     Heart Disease

Other: \_\_\_\_\_

## FAMILY HISTORY

- Glaucoma     Macular Degeneration     Cataracts     Cancer – eyes/lids  
 Heart Disease     Thyroid Disease     Diabetes     High Blood Pressure

Other: \_\_\_\_\_