

PATIENT HISTORY

OCULAR INFORMATION: circle all that apply

Ocular History:

Blurred vision-distance	Itching	Headaches	Redness
Blurred vision-near	Tearing	Flashing lights	Light sensitive
Fluctuating vision	Floating Spots	Burning	Temporary loss of vision

Ocular Surgery:

None	Muscle	Retinal Surgery
PRK	RK/AK	ALK/LASIK
Cataract	Corneal Transplant	

Comments: _____

Contact Lens History:

None	Soft Daily Wear	Soft Overnight Wear
Soft Toric	RGP or PMMA	Number of years: _____
Difficulty with CL Wear: Yes No		Contact Lens Last Used: _____

Comments: _____

Eyeglass History:

None	Near Vision	Progressive
Distance	Bifocals	Number of Years: _____

Medical Information

Allergies: None List: _____

Medications: None List: _____

General Health Problems: _____

Arthritis: Yes No Heart Disease: Yes No Cancer/Tumor: Yes No

Diabetes: Yes No Shingles: Yes No Lung Disease: Yes No

Thyroid: Yes No Cholesterol: Yes No High Blood Pressure: Yes No

Glaucoma: Yes No