PATIENT HISTORY

Name: _____ Date: _____

Please check all that apply: Date: _____

Do you ever experience any of the following: Date: _____

□ Blurred vision-distance □ Itching □ Dryness □ Pain □ Glare

□ Blurred vision-near □ Headaches □ Flashing lights □ Light sensitive □ Eye Injury

□ Fluctuating vision □ Tearing □ Floating Spots □ Double Vision

□ Temporary loss of vision □ Burning □ Redness □ Eye Strain

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:

□ Eye turn/Muscle □ Retina □ Cataract □ Glaucoma □ Cornea

□ Vision Correction – PRK, LASIK, RK, AK, ALK

Comments: _____

Eyeglass History:

□ None □ Reading □ Distance □ Progressive □ Bifocals Number of Years:_____

Contact Lens History:

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

Number of years: _____ Current Contact Lens: _____

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

Comments: _____

Medical Information:

□ Diabetes □ High Blood Pressure □ Cholesterol □ Thyroid □ Arthritis

□ Heart Disease □ Migraine □ Lung Condition □ Cancer

□ Pregnant / □ Nursing □ Current Smoker □ Previous Smoker

Other: _____

Medications: □ None List: _____

Allergies: □ None □ Pollen □ Dust □ Animal Other: _____

FAMILY HISTORY

□ Glaucoma □ Macular Degeneration □ Cataracts □ Cancer – eyes/lids

□ Diabetes □ High Blood Pressure □ Heart Disease □ Thyroid Disease

Other: _____