Patient History: This will help provide the best possible care and is required by insurances.

Name:_____Occupation:_____

Why are you here today?_____

When was your last eye exam?_____Dr's Name:_____

Do you wear glasses?_____When?_____

Do you wear contact lenses?_____Type_____Schedule_____Solutions_____

Do you have occupational or avocational needs(Describe)_____

Do you have/have you had:(Check all that apply):

❒ Distance blur	❒ Near blur	❒ Headaches
❒ Eyestrain	❒ Tiredness	❒ Burning/dryness
❒ Itching	❒ Redness	❒ Tearing/Discharge
❒ Double vision	❒ Floaters	❒ Flashes
❒ Glaucoma	❒ Cataracts	❒ Eye infection/injury
❒ Eye surgery	❒ Color vision problem	❒ Other

Health History:

Your last physical exam_____Dr's Name_____

Do you have/do you use:(Check all that apply)

❒ High blood pressure	❒ Heart disease	❒ Diabetes
❒ Thyroid disease	❒ Arthritis	❒ Autoimmune disease
❒ Neurologic problems	❒ Ear/Nose/Throat problem	❒ Other systemic illness
❒ Allergies:(List)	❒ Medications:(List)	❒ Alcohol ❒ Cigarettes/tobacco ❒ Other substances

Family History:

In close relatives:(Check all that apply)

❒ High blood pressure	❒ Heart disease	❒ Diabetes
❒ Glaucoma	❒ Cataracts	❒ Macular degeneration
❒ Retinal detachment	❒ Other	❒

Additional information:_____

_____

Signature_____Date_____