

Patient's Name _____

Date _____

Ocular History

Approx. date of last full eye exam: _____ by Doctor: _____ City: _____ State: _____

What is the main reason for your visit? _____

Do you wear glasses? _____ Age of current pair? _____ How many hours a day are you on the computer? _____

Do you wear contact lenses? _____ Age of current pair? _____ Type of contact lenses: _____

Check if you have:

- | | | | |
|--------------------------------------|-------------------------|------------------------|-------------------------------|
| _____ Blurred vision at distance | _____ Loss of Vision | _____ Tearing | _____ Sandy or gritty feeling |
| _____ Blurred vision at near | _____ Double vision | _____ Itching | _____ Eyelid problem |
| _____ Blurred vision at intermediate | _____ Eye pain | _____ Mucous discharge | _____ Tired Eyes |
| _____ Flashes | _____ Redness | _____ Burning | _____ Headaches |
| _____ Floaters / Spots in Vision | _____ Light sensitivity | _____ Dry eyes | |

Other: _____

Is there a history with you or your family of any of the following conditions?

- | | | | |
|---|----------------------------|-------------------------|--------------------|
| _____ Glaucoma | _____ Macular Degeneration | _____ Blindness | _____ Lazy eye |
| _____ Cataracts | _____ Retinal Disease | _____ Poor color vision | _____ Crossed eyes |
| _____ Eye surgery – what type? _____ | | | When? _____ |
| _____ Serious eye injury – what type? _____ | | | When? _____ |

Medical History

Present medical conditions:

Present medications/supplements you are taking:

Medications you are allergic to:

Contact lens solutions you use:

PLEASE TURN OVER

Check if you have, or have ever had problems in the following areas:

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Eczema | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Constipation | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Vascular disease | <input type="checkbox"/> Kidney | <input type="checkbox"/> Anemia | <input type="checkbox"/> Muscle or joint pain | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Unexplained weight change | <input type="checkbox"/> Bladder | <input type="checkbox"/> Sickle cell | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> HIV | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Fever | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Bronchitis |
| <input type="checkbox"/> Emphysema | | | | |

Check if you or your parents, children, grandparents, or siblings have had:

- | | | | | |
|-----------------------------------|--|--|---|--------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Kidney disease | |

Relationship to you: _____

Are you pregnant or nursing? Yes / No

Social History

This information is kept strictly confidential. However, you may discuss this with the doctor if you prefer.

Yes, I would prefer to discuss this portion directly with the doctor. _____ I choose not to discuss my social history _____

Do you drive? Yes / No If yes, do you have difficulty driving? _____

Do you use tobacco or smoke? Yes / No If yes, what type/amount/how long? _____

Do you drink alcohol? Yes / No If yes, what type/amount? _____

Do you use illegal drugs? Yes / No If yes, what type/amount? _____

- Have you ever been exposed to or infected with:
- | | | |
|------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Histoplasmosis |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> HIV | <input type="checkbox"/> Toxoplasmosis |

Signature (or Guardian Signature): _____