NAME:_____ **Date of Birth:**_____ **Today's Date:**_____

How long ago was your last eye exam? _____ **Who was your last eye doctor**? _____

What is your primary eye correction?

□ None	□ Contacts	□ Over the Counter Readers	□ Bifocals	□ Progressives	□ Single Vision	□ Trifocals

What are your hobbies and special vision correction needs?_____

_____

What is your computer use?	□ None	□ 1-2 hours/day	□ 3-6 hours/day	□ 7 + hours a day
Tablet/smart phone/handheld gaming use?	□ None	□ 1-2 hours/day	□ 3-6 hours/day	□ 7 + hours a day

Do you have computer glasses? □ Yes □ No

What eye surgeries have you had?

□ None	□ Cataract	□ LASIK	□ Lid	□ PRK	□ RK	□ Other_____

Eye History: Please check all that apply:

□ Blind eye	□ Eye infections	□ Macular degeneration
□ Blurry Distance Vision	□ Floaters	□ Retinal Detachment
□ Blurry Near Vision	□ Glaucoma	□ Seeing Flashes of Light
□ Cataracts	□ Eye Injury	□ Temporary Loss of Vision
□ Dry Eyes	□ Itchy Eyes	□ Lazy Eye

Are you interested in Contact Lenses? □ Yes □ No □ Unsure

What type of contacts have you worn?

□ None	□ Astigmatism Correcting	□ Extended Wear	□ Gas Permeable	□ Monovision	□ Multifocal	□ Soft

If you wear contact lenses, what is your replacement schedule?□ Daily □ 2 Week □ Monthly □ Other _____
Do you sleep in your contact lenses?□ Never □ Always □ Frequently □ Seldom □ Naps Only

Are you pregnant or nursing?	□ No	□ Yes, Pregnant	□ Yes, nursing
Smoking history:	□ No, never	□ Yes, current	□ Yes, past
Marijuana use:	□ No	□ Recreational	□ Medical

Medical History: Please check all that apply to your history

□ Asthma	□ Cancer	□ Gout	□ Herpes	□ Low Thyroid
□ Allergies	□ Depression	□ Hypertension	□ Migraines	□ High Thyroid
□ Arthritis	□ Food Allergies	□ High Cholesterol	□ Pollen Allergy	□ Other: _____

Diabetic History:

Do you have: □ Diabetes 1 □ Diabetes 2 □ Pre-Diabetes □ **None**

If you have Diabetes, when was it diagnosed? _____

What was your last A1C? _____When was it taken? _____

What was your last fasting blood sugar?_____ When was it taken? _____

Is there a family medical history of any of the following?	Is there a family eye history of any of the following?
□ Not known	□ Not known
□ Cancer	□ Blindness
□ Diabetes	□ Retinal Detachment
□ Heart Disease	□ Macular Degeneration
□ High Blood pressure	□ Glaucoma
□ Other:_____	□ Lazy eye
	□ Other:_____

Review of Systems: **Do you CURRENTLY have any problems in these areas**? Check the boxes that correspond to the systems in the right column. **If you have no problems in a system, please check none.**

System					
General	□ None	□ Cancer	□ Weight Gain	□ Weight Loss	□ Other _____
Ears, nose, throat:	□ None	□ Cough	□ Dry Mouth	□ Hard of hearing	□ Other_____
Cardiovascular	□ None	□ High blood pressure	□ Vascular Disease		□ Other_____
Respiratory:	□ None	□ Asthma	□ Sleep apnea	□ COPD	□ Other_____
Genital, Kidney, Bladder	□ None	□ Frequent urination			□ Other_____
Muscles, Bones, Joints	□ None	□ Lupus	□ Rheumatoid Arthritis		□ Other_____
Skin	□ None	□ Skin Cancer	□ Rosacea		□ Other_____
Neurological	□ None	□ Headaches	□ Stroke	□ Seizures	□ Other_____
Psychiatric	□ None	□ Depression	□ Anxiety		□ Other_____
Endocrine	□ None	□ Low Thyroid	□ High Thyroid		□ Other_____
		□ Diabetes Type 1	□ Diabetes Type 2		
Blood/Lymph	□ None	□ High Cholesterol			□ Other_____
Allergic/Immune	□ None	□ Hay fever	□ Immune Disorder		□ Other_____

List all Eye Medications and Drops (prescription & over-the-counter): □ None _____

_____

List ALL MEDICATIONS (including over the counter and vitamins): □ None _____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? □ NONE KNOWN □ YES (LIST):

Who is your Primary Care Physician? _____

Additional notes or information: _____

_____

I verify this medical and eye history form is complete and correct to the best of my knowledge.

Signed: _____ Date:_____

Printed: _____