Vision and Medical History

Stewart OPTICAL

What is the reason for your visit today? _____

Date of last eye exam (estimate) :_____

Are you having any of the following? (while wearing glasses/ CL if prescribed) Check all that apply

- ☐ Blurry Vision
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Light Sensitivity
- ☐ Itching
- ☐ Poor Night Vision
- ☐ Headaches
- ☐ Redness
- ☐ Burning
- ☐ Tearing

What medications are you currently prescribed?

_____

Are you allergic to any medications? NO / YES: If so, please list:_____

Have you ever had any eye surgeries or conditions? Patching as a child, metal removed, etc.

_____

Do you OR an immediate family member have a history of any of the following? Check all that apply. (Please state if self or family member on the line provided)

- ☐ Arthritis_____
- ☐ Cancer _____
- ☐ Diabetes _____last A1C:_____
- ☐ Heart disease_____
- ☐ High Blood Pressure_____
- ☐ Thyroid Disease_____
- ☐ Skin Disorders_____
- ☐ Asthma_____
- ☐ Allergies_____

Have you OR an immediate family member ever had any of the following eye diseases or injuries? (Please state if self or family member on the line provided)

- ☐ Macular Degeneration _____
- ☐ Glaucoma _____
- ☐ Cataracts _____
- ☐ Corneal Disease _____
- ☐ Retinal Detachment _____
- ☐ Other: _____

Location of your Primary Care Physician: Aspirus, Marshfield Clinic, Quad Med, Other:_____

Do you wear contact lenses? Yes / No **Are you Pregnant?** Yes / No

PRINT: _____

SIGN: _____ **DATE**: _____