PERSONAL HISTORY

What eye or vision concerns prompted your visit today?

_____

Have you been diagnosed with any of the following eye conditions?

Y N Cataract
Y N Age related macular degeneration
Y N Glaucoma
Y N Diabetes
Y N Diabetic retinopathy
Y N Dry eye
Y N Eye infection, inflammation, or allergy
Y N Floaters and/or flashes of light
Y N Iritis or uveitis
Y N Retina defects or degenerations
Y N Other

Are you experiencing any of the following eye concerns?

Y N Redness
Y N Burning
Y N Itching
Y N Tearing
Y N Discharge
Y N Other

Are you experiencing any of the following vision concerns?

Y N Blurred vision
Y N Eyestrain
Y N Eye pain
Y N Severe light sensitivity
Y N Headache
Y N Poor night vision
Y N Bothersome night glare
Y N Double vision
Y N Total loss of vision
Y N Other

Are you interested in any of the following?

Y N New contact lens fitting
Y N New technology or more comfortable contact lenses
Y N One-day use contact lenses
Y N Contact lenses of a different replacement period
Y N Laser vision correction

What corrective lenses are you using for far/distant vision activities?

❒ No Correction ❒ Eyeglasses ❒ Contact Lenses

Describe the quality of your far/distant vision activities:

❒ Acceptable ❒ May Need Improvement ❒ Blurred

What corrective lenses are you using for near/reading vision activities?

❒ No Correction ❒ Eyeglasses ❒ Contact Lenses
❒ Contact Lenses with Glasses

Describe the quality of your near/reading vision activities:

❒ Acceptable ❒ May Need Improvement ❒ Blurred

What corrective lenses are you using for computer vision activities?

❒ No Correction ❒ Eyeglasses ❒ Contact Lenses
❒Contact Lenses with Glasses

Describe the quality of your computer vision activities:

❒ Acceptable ❒ May Need Improvement ❒ Blurred

PERSONAL HEALTH HISTORY **If yes please circle the appropriate conditions**

Have you been told you have any of the following conditions?

Y N Constitution (i.e. developmental or learning disabilities, cancer)
Y N Ear, nose, throat conditions
Y N Neurological (i.e. stroke, epilepsy, multiple sclerosis, migraine)
Y N Psychiatric (i.e. depression, anxiety disorder, attention deficit disorder, bipolar disorder)
Y N Cardiovascular (i.e. high blood pressure, heart failure, heart disease)
Y N Respiratory (i.e. asthma, COPD, emphysema, sleep apnea)
Y N Gastrointestinal (i.e. Crohn's disease, colitis, ulcer, Celiac disease, acid reflux)
Y N Genitourinary (i.e. kidney disease, prostate disease, STD/STI)
Y N Musculoskeletal (i.e. ankylosing spondylitis, gout, arthritis, osteoporosis)
Y N Integumentary (i.e. rosacea, psoriasis, Herpes Simplex/cold sores, Herpes Zoster/shingles)
Y N Endocrine (i.e. diabetes mellitus type 1 or 2, thyroid dysfunction)
Y N Hemotologic/Lymphatic (i.e. high cholesterol levels, anemia)
Y N Allergic/Immune (i.e. Lupus, Sjogren's syndrome, rheumatoid arthritis, environmental allergies)
Y N Are you pregnant or nursing

Are you currently taking any medications (over the counter and/or prescribed by a doctor)? Y N

Please list _____

Are you currently using any eye drops (over the counter and/or prescribed by a doctor)? Y N _____
Are you allergic to any medications or latex? Y N _____
Do you drink alcohol? If so, please list how many drinks/week. Y N _____
Do you use tobacco products? If so, please list type and amount used/week. Y N _____
Please list your occupation and hobbies_____
Have you had eye surgery? Y N _____

FAMILY HISTORY

Has anyone in your family been diagnosed with the following conditions?

Y N Skin or eye cancer
Y N Diabetes mellitus type 1
Y N Diabetes mellitus type 2
Y N High blood pressure
Y N Thyroid issues
Y N Congenital cataracts
Y N Age related macular degeneration
Y N Glaucoma
Y N Other eye conditions _____