Please complete the following health history

Reason for today's visit: _____

Occupation:_____ When was your last eye exam?_____ Where?_____

Do you presently wear glasses?† Yes † No † Full time † Distance Only † Reading Only † Computer

Do you wear contact lenses? † Yes † No If yes, what brand? _____

Are you experiencing any of the following eye/vision problems? (*Please circle all that apply*)

† Itchy eyes	† Watery eyes	† Flashes
† Pain/Soreness	† Tired eyes	† Floaters
† Red Eye	† Light Sensitivity	† Headaches
† Burning Stinging	† Blurred Vision	† Previous eye injury _____
† Discharge	† Double Vision	† Previous eye surgery _____
† Dryness/Sandy/Gritty	† Loss of Vision	† Other (describe) _____

Have **<u>you</u>** ever been diagnosed as having any of the following?

Cataracts	† Yes	† No	When_____	Respiratory	† Yes	† No	When_____		
Glaucoma	† Yes	† No	When_____	High Blood Pressure	Yes	† No	When_____		
Macular Degeneration	† Yes	† No	When_____	Cancer	† Yes	† No	When_____		
Lazy Eye	† Yes	† No	When_____	Cholesterol	† Yes	† No	When_____		
Diabetes	† Yes	† No	When_____	Thyroid	† Yes	† No	When_____		
Retinal Detachment/ Disease	† Yes	† No	When_____	Other (describe) _____					

Has **<u>anyone in your family</u>** ever been diagnosed as having any of the following?

Blindness	† Yes	† No	Who_____	Cancer	† Yes	† No	Who_____		
Macular Degeneration	† Yes	† No	Who_____	Diabetes	† Yes	† No	Who_____		
Retinal Detachment/ Disease	† Yes	† No	Who_____	Heart Disease	† Yes	† No	Who_____		
Glaucoma	† Yes	† No	Who_____	High Blood Pressure	† Yes	† No	Who_____		

Are you currently taking any medications? (Prescription, non-prescription, home remedies, vitamins) † None

1. _____	3. _____	5. _____	7. _____
2. _____	4. _____	6. _____	8. _____

Do you have any allergies? _____

Are you allergic to any medication or anesthesia? (List and describe reaction)_____

Do you smoke? † Yes No Are you pregnant? Yes No

Are you interested in finding out about contact lens options for yourself? Yes No

Are you interested in finding out about laser vision correction? Yes No

Signature:_____ Date: _____