Name: _____ Birth Date: _____ Todays date: _____

General Info

Who is your medical doctor?

_____

Who was your previous eye doctor?

_____

When was your last eye exam?

_____

What brings you to the office today?

_____

_____

_____

Current Medications

What Medications are you taking?

Name	Dosage	Frequency

(Any additional medications please provide a list)

Eyes

Have you ever had any of the following? (Please check)

- ☐ None
- ☐ Blurred Vision
- ☐ Cataract
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Drooping eyelids
- ☐ Glaucoma
- ☐ Retinal Disease
- ☐ Eye Injury

- ☐ Laser Surgery When? _____
- ☐ Do you wear glasses?
- ☐ Do you wear contacts?

_____
Brand

_____
Wearing schedule

_____
Solutions

Current Allergies

What are you allergic to?

Allergy	Reaction

Medical History

Have you ever had any of the following? (Please tick)

- ☐ None
- ☐ AIDS / HIV
- ☐ Anxiety / Depression
- ☐ Cancer
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Diabetes

Have you ever had or been treated for any of the following?

- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Hepatitis
- ☐ Herpes Simplex
- ☐ Shingles

Family History

Has any family member had any of the following? (Please check)

	Who?
☐ Blindness	_____
☐ Crossed eye / Lazy eye	_____
☐ Glaucoma	_____
☐ Macular degeneration	_____
☐ Diabetes	_____

Lifestyle

Are you pregnant or nursing? NO YES

Do you drink Alcohol? NO YES
How long? _____

Do you use recreational drugs? NO YES
Types and how often? _____

Do you smoke? NO YES
How many/ how long? _____

Do you have difficulty driving? NO YES
How? _____