HEALTH HISTORY

Name _____ Age _____

Reason for today's exam _____

_____

Date of last exam _____ Name of eye doctor _____

Do you or anyone in your immediate family have a history of the following?

- ☐ Diabetes
- ☐ Blindness
- ☐ High blood pressure
- ☐ Cataracts
- ☐ Thyroid
- ☐ Turned or lazy eye
- ☐ Glaucoma
- ☐ Heart condition

Please check any of the following conditions that apply to you:

- ☐ Frequent headaches
- ☐ Drug allergies
- ☐ Pregnant
- ☐ Allergies
- ☐ Sinus trouble
- ☐ Have given birth in the last 6 months

Please list all medications you are currently taking: _____

Have you ever had any of the following conditions involving your eyes?

- ☐ Eye surgery
- ☐ Sensitivity to light
- ☐ Eye infection or disease
- ☐ Eye injury
- ☐ Floaters or spots
- ☐ Double vision
- ☐ Medical treatment
- ☐ Poor distance vision
- ☐ Eye strain
- ☐ Severe pain
- ☐ Poor near vision
- ☐ Eyes burn, itch, or water

Do you currently wear glasses? ☐ Yes ☐ No

When do you wear your glasses?

- ☐ All the time
- ☐ Reading/near work
- ☐ Work safety
- ☐ Distance tasks only
- ☐ Computer work
- ☐ Other, please explain _____

Have you ever worn contacts? ☐ Yes ☐ No

Are you interested in wearing contact lenses? ☐ Yes ☐ No

If so, what style?

- ☐ Soft
- ☐ Extended Wear
- ☐ Gas Permeable
- ☐ Bifocal
- ☐ Tinted
- ☐ Astigmatic
- ☐ Disposable
- ☐ Unsure

Do you work at a computer or video display terminal? ☐ Yes ☐ No

What hobbies or sports do you participate in? _____

X _____

SIGNATURE OF PATIENT (Or parent if a minor) DATE