

## EYE HEALTH HISTORY

Date of last eye exam \_\_\_\_\_ Place a mark on "Yes" to indicate if you have had any of the following:

Name of doctor \_\_\_\_\_

Do you wear glasses?  Yes  No  
 All the time  Occasionally  
 Reading  Driving  TV

Do you wear contacts?  Yes  No  
 Type \_\_\_\_\_ Hours/Day \_\_\_\_\_

Describe any problems you have with your contacts \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Bloodshot Eyes	<input type="checkbox"/> Yes	Floaters or Spots	<input type="checkbox"/> Yes
Blurred Vision - Distance	<input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> Yes
Blurred Vision - Near	<input type="checkbox"/> Yes	Headaches	<input type="checkbox"/> Yes
Burning Eyes	<input type="checkbox"/> Yes	Itching Eyes	<input type="checkbox"/> Yes
Cataracts	<input type="checkbox"/> Yes	Light Sensitive	<input type="checkbox"/> Yes
Color Vision, Poor	<input type="checkbox"/> Yes	Loss of Vision	<input type="checkbox"/> Yes
Crossed Eyes	<input type="checkbox"/> Yes	Migraine Headaches	<input type="checkbox"/> Yes
Discharge from Eyes	<input type="checkbox"/> Yes	Night Vision, Poor	<input type="checkbox"/> Yes
Dizzy Spells	<input type="checkbox"/> Yes	Red Eyes	<input type="checkbox"/> Yes
Double Vision	<input type="checkbox"/> Yes	Seeing Halos	<input type="checkbox"/> Yes
Dry Eyes	<input type="checkbox"/> Yes	Seeing Flashes	<input type="checkbox"/> Yes
Eye Infection	<input type="checkbox"/> Yes	Temporary Loss of Vision	<input type="checkbox"/> Yes
Eye Injury	<input type="checkbox"/> Yes	Twitching Eyelid	<input type="checkbox"/> Yes
Eye Strain	<input type="checkbox"/> Yes	Vision Poor	<input type="checkbox"/> Yes
Fainting Spells, Blackouts	<input type="checkbox"/> Yes	Watering Eyes	<input type="checkbox"/> Yes

## HEALTH HISTORY

Family Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Place a mark on "Yes" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Lazy Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Poor Color Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Retinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Shingles	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Drug Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Skin Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Thyroid Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Eye Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Turned Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Are you pregnant? _____	Number of Children _____	
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Tobacco use _____	Alcohol use _____	
Hepatitis (Type _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Other _____		

### MEDICATIONS

List medications you are currently taking, including eye drops:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone \_\_\_\_\_

### ALLERGIES

List your allergies to medications or other substances:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_