Date: _____

Family Dr: _____

Optometrist: _____ Alternate Contact Name: _____

Occupation: _____ Alternate Contact Phone: _____

Reason for Visit: _____

EYE HISTORY

Do you wear glasses? ☐ No ☐ Yes ☐ Bifocal ☐ Readers ☐ Distance only

Do you contact lenses? ☐ No ☐ Yes ☐ Disposable ☐ Soft ☐ Rigid

How many hours per day do you wear your contact lenses? _____

	Right	Left	Dates and/or Duration
Cataracts	☐	☐	_____
Cataract Surgery	☐	☐	_____
Glaucoma	☐	☐	_____
Glaucoma Surgery	☐	☐	_____
Retina surgery	☐	☐	_____
Laser surgery	☐	☐	_____
Macular Degeneration	☐	☐	_____
Lazy Eye	☐	☐	_____
Herpes of the eye	☐	☐	_____
Shingles of the eye	☐	☐	_____
Iritis	☐	☐	_____
Other	☐	☐	_____

Eye drops being used:

_____	☐	☐	Times per day: _____
_____	☐	☐	Times per day: _____
_____	☐	☐	Times per day: _____
_____	☐	☐	Times per day: _____

	Yes	No	
Do you currently drive a car?	☐	☐	
Do you limit your driving?	☐	☐	Why? _____

ALLERGIES

Drug: ☐ None ☐ Penicillin ☐ Sulfa ☐ Local Anesthetic

Environmental: _____

Other: _____

OFFICE USE ONLY:

CURRENT MEDICATIONS

List your current medications	This medication is taken for what condition?

MEDICAL HISTORY *Do you or have you ever had, any of the following conditions?*

	Yes	Date/Duration		Yes	Date/Duration
High blood pressure	☐		Stomach ulcer	☐	
Stroke	☐		Hiatus hernia	☐	
Heart attack	☐		Nerve disorder	☐	
Angina	☐		Shingles	☐	
Irregular heart beat	☐		Multiple Sclerosis	☐	
Heart murmur	☐		Chronic headaches	☐	
Asthma	☐		Rheumatoid Arthritis	☐	
Emphysema	☐		Other Arthritis	☐	
Hayfever/sinusitis	☐		Lupus	☐	
Kidney disorder	☐		Skin disorder	☐	
Jaundice / hepatitis	☐		Thyroid disorder	☐	
Colitis	☐		Blood disorder	☐	
Diabetes	☐		Cancer	☐	
Insulin?	☐		Type:		

SURGICAL HISTORY

	Date:

FAMILY HISTORY Do any of your(blood relatives have any of the following conditions?

	Yes	Who?		Yes	Who?
Glaucoma	❑		Cataract	❑	
Lazy eye	❑		Blindness	❑	
Retinal detachment	❑		Other eye disorder	❑	
Macular degeneration	❑		Diabetes	❑	

Do you have any specific questions you want the doctor to answer?