PATIENT HEALTH HISTORY

Print Name:_____

Primary Care Physician
Or Family Doctor:_____

Do you wear Contacts? ◯NO ◯YES ◯Hard ◯Soft ◯Disposable Brand:

Do you wear Glasses? ◯NO ◯YES ◯Single Vision ◯Bifocal ◯Trifocal ◯Progressive

PATIENT EYE HEALTH	Yes	No
Glaucoma	◯	◯
Cataracts	◯	◯
Lazy Eye	◯	◯
Dry Eyes	◯	◯
Retina Problems	◯	◯
Eye Infections	◯	◯
Eye Injury	◯	◯
Cataract Surgery	◯	◯
Laser Surgery	◯	◯
Refractive Surgery	◯	◯

PATIENT MEDICAL HISTORY	Yes	No
Diabetes	◯	◯
High Blood Pressure	◯	◯
Heart Problems	◯	◯
Respiratory Problems	◯	◯
Thyroid	◯	◯
Cholesterol	◯	◯
Auto-immune Disease	◯	◯
Headaches	◯	◯
Ears/Nose/Throat Issues	◯	◯
Pregnant or Lactating	◯	◯
Arthritis	◯	◯

FAMILY EYE HISTORY	Yes	No
Macular Degeneration	◯	◯
Glaucoma	◯	◯
Cataracts	◯	◯
Lazy Eye	◯	◯
Retina Problems	◯	◯
Blindness	◯	◯

FAMILY MEDICAL HISTORY	Yes	No
Diabetes	◯	◯
High Blood Pressure	◯	◯
Heart Problem	◯	◯
Other [ ]	◯	◯

HAVE YOU EVER USED.....	Yes	No
Tobacco	◯	◯
Alcohol	◯	◯

ARE YOU or DO YOU.....	Yes	No
Sensitive to light	◯	◯
Have excessive exposure to the sun	◯	◯
Light eyes, light skin	◯	◯

GENERAL MEDICATIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

EYE MEDICATIONS—EYE DROPS

_____
_____
_____
_____
_____

Allergic to:_____

Signed:_____