Patient name: _____ Date of birth: _____
Employer: _____ Occupation/Title: _____
Emergency contact name: _____ Emergency phone: _____
Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian ☐ Hawaiian ☐ Hispanic
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic or Latino Preferred Language: ☐ English ☐ Spanish ☐ Other

EYE HEALTH HISTORY

What prompted your visit? _____
Date of last eye exam: _____ Name of previous eye doctor: _____
Do you wear glasses? ☐ All the time ☐ Occasionally ☐ Rarely ☐ Never
How do you use your glasses? ☐ Reading ☐ Driving ☐ Computer ☐ Sports ☐ TV
If you do not currently wear contact lenses, are you interested in learning more about them? ☐ Yes ☐ No
What type of contact lenses do you wear (if any)? ☐ Soft daily wear ☐ Toric ☐ Multifocal ☐ Monovision ☐ Gas permeable
On average, how many hours/day do you wear your contact lenses? _____
How often do you throw out your contact lenses? ☐ Daily ☐ Every 2 weeks ☐ Every month ☐Other:_____
Do you have any eye problems other than corrective lenses? Check the box if you currently have any of the following:

☐ Bloodshot eyes ☐ Eye strain/tired eyes ☐ Watering eyes
☐ Burning eyes ☐ Floaters/Flashes ☐ Dry Eyes
☐ Poor color vision ☐ Itching eyes ☐ Eye Turn (in or out)
☐ Eye Turn (in or Out) ☐ Light sensitivity ☐ Headaches
☐ Double vision ☐ Loss of vision ☐ Other: _____

Have you ever had surgery on your eyes? ☐No ☐Yes, Type:_____ Date:_____
Do you or any of your family members have any eye diseases?

Blindness ☐ Self ☐ Family member: _____ Macular degeneration ☐ Self ☐Family member: _____
Lazy eye ☐ Self ☐ Family member: _____ Glaucoma ☐ Self ☐Family member: _____
Cataracts ☐ Self ☐ Family member: _____

HEALTH HISTORY

Primary Care Physician's Name: _____ Date of Last Visit: _____
Clinic Name: _____ Height: _____ Weight: _____
Medications: Please list all medications you are taking (prescribed and over the counter), INCLUDING vitamins and eye drops:
_____
_____
Allergies: Please list all medications you are allergic to:
_____
_____
Please check the box if you or someone in your family has had any of the following:

Self Family
Cardiovascular
☐ ☐ Heart disease
☐ ☐ Elevated cholesterol
☐ ☐ High blood pressure
Constitutional
☐ ☐ Car sickness
☐ ☐ Dizziness
Endocrine
☐ ☐ Diabetes
Last blood sugar reading:___
Last A1c:_____
☐ ☐ Thyroid disorder
☐ ☐ Pituitary disorder
☐ ☐ Kidney disease
Gastrointestinal
☐ ☐ Cirrhosis
☐ ☐ Colitis
☐ ☐ Hepatitis Type:_____
☐ ☐ Inflammatory bowel syndrome
Genitourinary
☐ ☐ Prostate Cancer
☐ ☐ Syphilis

Self Family
Head/Ears/Nose/Throat
☐ ☐ Headaches
☐ ☐ Sinusitis
☐ ☐ Hearing loss
Hematology/Lymphatic
☐ ☐ Breast carcinoma
☐ ☐ Cavernous sinus thrombosis
☐ ☐ Sickle cell disease
☐ ☐ Temporal arteritis
Integumentary
☐ ☐ Lupus
Immunologic
☐ ☐ AIDS
☐ ☐ Shingles (Herpes Zoster)
☐ ☐ HIV positive
☐ ☐ Lyme disease
☐ ☐ Sjogren's Syndrome
Musculoskeletal
☐ ☐ Arthritis
☐ ☐ Myasthenia gravis
Neurological
☐ ☐ Traumatic brain injury
☐ ☐ Cerebral palsy
☐ ☐ Multiple sclerosis
☐ ☐ Epilepsy/seizures

Self Family
Psychiatric
☐ ☐ Attention disorder
☐ ☐ Alzheimer's disease
☐ ☐ Anxiety
☐ ☐ Depression
☐ ☐ Learning disability
Respiratory
☐ ☐ Asthma
☐ ☐ Emphysema
☐ ☐ Sarcoidosis
☐ ☐ OTHER: _____
Do you use Alcohol?
☐ Never
☐ Rarely
☐ Moderate
☐ Daily
Do you use tobacco products?
☐ Never
☐ Previously: Date quit:_____
☐ Currently: Packs/day:_____
Are you currently pregnant?
☐ Yes
☐ No

Patient/Guardian Signature: _____ Date: _____
Doctor's Signature: _____ Date: _____