Patient Name:___________________________________ Date:__________________________

Patient Eye History

Date of Last Eye Exam: ________________________

Where? _______________________________

Have you had any eye-related surgeries of any kind?
Yes [ ] No [ ]

Have you ever experienced, been diagnosed or treated for any of the following?

[ ] Blurry Vision
[ ] Burning
[ ] Cataracts
[ ] Crossed eye/Eye turn
[ ] Double Vision
[ ] Trouble seeing at night
[ ]Eye Infections
[ ] Eye Injury
[ ] Flash of light
[ ] Floaters/Spots
[ ] Glaucoma
[ ]Grittiness
[ ]Headaches
[ ]Iritis/Uveitis
[ ] Itchiness
[ ] Lazy Eye
[ ] Macular Degeneration
[ ] Occasional dryness
[ ] Retinal Detachment
[ ] Tearing

Other eye disorders: ______________________

Family Medical/Eye history

Family history of any of the following? (check all that apply and indicate mother or father's side):

	Relationship (Mother's or Father's side)
Blindness	[ ]_________________
Cataracts	[ ]__________________
Corneal Problems	[ ]__________________
Diabetes	[ ]__________________
Glaucoma	[ ]___________________
Heart Disease	[ ]__________________
Lazy Eye	[ ]__________________
Macular Degeneration	[ ]___________________
Retinal Problems	[ ]___________________

Patient Medical History

Name of Family Physician: ______________________

Address: __________________________________

Date of Last Physical Check-Up: ____________

Current Medications (Rx or Over-The-Counter)

(List name of medications, including eye drops, vitamins & birth control pills, dosages, and frequency. Please bring a list if possible!):___________________________________

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Have you ever been diagnosed or treated for the following health problems? Check all that apply

[ ] Allergies
[ ] Arthritis
[ ] Blood/Lymph
[ ] Bronchitis
[ ] Cancer
[ ] Cholesterol
[ ] Diabetes
[ ] Digestive
[ ] Ears/Nose/Throat
[ ] Endocrine
[ ] Eczema/Rashes
[ ] Fatigue
[ ] Fevers
[ ] Genitourinary
[ ] High Blood Pressure
[ ]Integumentary (Skin)
[ ] Kidney
[ ] Muscle/Bone
[ ] Neurological
[ ] Psychological
[ ] Respiratory
[ ] Sinus
[ ] Throat Infections
[ ]Thyroid
[ ] Unusual weight losses/gains