

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Date of last eye exam: _____

Name of doctor: _____

Date of last physical: _____

Name of doctor: _____

Please check if you wear:

- Glasses Distance Reading
- Bifocal/Progressive

- Contacts wear every day
- wear occasionally
- sleep in lenses

Medications currently taking, including **eye drops**:

Allergies to medications or substances:

Are you experiencing any problems with your **current glasses or contact lenses**? Please explain:

Are you experiencing any problems with your **vision or eyesight**? Please explain:

In case of emergency, please provide a name and phone number of a person we can contact:

Please check if you, or an immediate blood relative, has had any of the following **EYE** problems:

- | | | |
|---|-------------------------------|--------------------------------|
| <input type="checkbox"/> LASIK/PRK | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Macular Degen | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Prosthetic Eye | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Retinal Detach | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tumor | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Foreign Body | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Eye Allergies | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |

Please check if you, or an immediate blood relative, has had any of the following **MEDICAL** problems:

- | | | |
|---|-------------------------------|--------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> High Blood Press | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Graves' Disease | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Thyroid Cond | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Self | <input type="checkbox"/> _____ |