EYE HEALTH HISTORY

1. Last eye exam: When _____, Where/ Name of doctor_____

2. Do you wear glasses? □ Yes, □ No, □ All the time, □ Occasionally, □ Reading, □ Driving, □ TV, □ Work

3. Do you wear contact lenses? □ Yes, □ No, Type:_____, Wearing Time: _____Hours/days

4. Eye symptoms: Place a mark on "Yes" or "No" to indicate if you have any of the following.

Bloodshot Eyes	□ Yes, □ No	Eye Pain	□ Yes, □ No
Blurred Vision - Distance	□ Yes, □ No	Eye Strain	□ Yes, □ No
Blurred Vision – Near	□ Yes, □ No	Floaters or Spots	□ Yes, □ No
Burning Eyes	□ Yes, □ No	Headaches	□ Yes, □ No
Color Vision Problem	□ Yes, □ No	Itching Eyes	□ Yes, □ No
Crossed (Turned) Eye	□ Yes, □ No	Light Sensitive	□ Yes, □ No
Discharge from Eyes	□ Yes, □ No	Night Vision Problems	□ Yes, □ No
Dizzy Spells	□ Yes, □ No	Seeing Flashes	□ Yes, □ No
Double Vision	□ Yes, □ No	Side Vision Problem	□ Yes, □ No
Dry Eyes	□ Yes, □ No	Twitching Eyelid	□ Yes, □ No
Eye Infection	□ Yes, □ No	Vision Loss	□ Yes, □ No
Eye Injury	□ Yes, □ No	Watering Eyes	□ Yes, □ No

5. Describe any problems you have with your eyes or vision. _____

_____

HEALTH HISTORY

1. Last general health exam: When_____, Where/Name of doctor_____

2. Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	□ Yes, □ No	□ Yes, □ No	Lupus	□ Yes, □ No	□ Yes, □ No
Arthritis	□ Yes, □ No	□ Yes, □ No	Migraine Headaches	□ Yes, □ No	□ Yes, □ No
Asthma	□ Yes, □ No	□ Yes, □ No	Multiple Sclerosis	□ Yes, □ No	□ Yes, □ No
Bleeding	□ Yes, □ No	□ Yes, □ No	Sarcoidosis	□ Yes, □ No	□ Yes, □ No
Cancer	□ Yes, □ No	□ Yes, □ No	Shingles	□ Yes, □ No	□ Yes, □ No
Chemical Dependency	□ Yes, □ No	□ Yes, □ No	Skin Condition	□ Yes, □ No	□ Yes, □ No
Diabetes	□ Yes, □ No	□ Yes, □ No	Stroke	□ Yes, □ No	□ Yes, □ No
Drug Sensitivity	□ Yes, □ No	□ Yes, □ No	Thyroid Condition	□ Yes, □ No	□ Yes, □ No
Emphysema	□ Yes, □ No	□ Yes, □ No	Tuberculosis	□ Yes, □ No	□ Yes, □ No
Epilepsy	□ Yes, □ No	□ Yes, □ No	Cataracts	□ Yes, □ No	□ Yes, □ No
Hay Fever	□ Yes, □ No	□ Yes, □ No	Eye Surgery	□ Yes, □ No	□ Yes, □ No
Heart Condition	□ Yes, □ No	□ Yes, □ No	Glaucoma	□ Yes, □ No	□ Yes, □ No
Hepatitis	□ Yes, □ No	□ Yes, □ No	Lazy Eye	□ Yes, □ No	□ Yes, □ No
High Blood Pressure	□ Yes, □ No	□ Yes, □ No	Macular Degeneration	□ Yes, □ No	□ Yes, □ No
Kidney Disease	□ Yes, □ No	□ Yes, □ No	Retinal Disease	□ Yes, □ No	□ Yes, □ No

3. Tobacco use: □ Yes, □ No

4. Question for female: Are you pregnant? □ Yes, □ No

5. Medications: List Medications you are currently taking, including eye drops : _____

_____

_____

6. Allergies: List your allergies (Environmental/ Medications/ other) : _____

_____

7. Health concerns or explanations : _____

_____

8. Remarks :_____

_____