EYE CARE HISTORY

EYE HEALTH HISTORY

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please indicate if you have had any of the following:

☐ Floaters and spots

☐ Glaucoma

☐ Headaches

☐ Itching Eyes

☐ Lazy Eye

☐ Light Sensitive

☐ Migraine Headaches

☐ Night Vision, Poor

☐ Retinal Disease

☐ Seeing Halos

☐ Seeing Flashes

☐ Temporary Loss of Vision

☐ Twitching Eyelid

☐ Watering Eyes

☐ Bloodshot Eyes

☐ Blurred Vision – Distance

☐ Blurred Vision – Near

☐ Burning Eyes

☐ Cataracts

☐ Color Vision, Poor

☐ Crossed Eyes

☐ Dizzy Spells

☐ Double Vision

☐ Droopy Eyelids

☐ Dry Eyes

☐ Eye Infection Eye Injury

☐ Eye Strain

☐ Fainting spells, Blackouts

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your eye doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses: ☐ All the time ☐ Occasionally ☐ Reading

☐ Driving ☐ TV

Do you wear contacts: ☐ Yes ☐ No

Type: \_\_\_\_\_\_\_\_ Hours/Day: \_\_\_\_\_\_\_\_\_

EYE SURGERY

Please indicate if you have had any of the following:

☐ Eyelid ☐ Cataract ☐ Other \_\_\_\_\_\_\_\_\_\_\_

☐ Facelift ☐ Glaucoma

☐ Botox ☐ Retina

HEALTH HISTORY

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate if you have had any of the following:

☐ AIDS/HIV

☐ Arthritis

☐ Artificial Heart Valve

☐ Artificial Joints

☐ Asthma

☐ Bleeding

☐ Cancer

☐ Chemical Dependency

☐ Diabetes

☐ Emphysema

☐ Epilepsy

☐ Eczema

☐ Hay Fever

☐ Heart Condition

☐ Hepatitis

☐ High Blood Pressure

☐ Kidney Disease

☐ Lupus

☐ Pacemaker

☐ Skin Cancer

☐ Skin Condition

☐ Stroke

☐ Thyroid Conditions

☐ Tuberculosis

Are you pregnant? \_\_\_\_\_\_\_\_\_

Tobacco use: \_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| MEDICTIONS | | ALLERGIES |
|  | |  |
| List medications you are currently taking: | | List your allergies to medicines or other substances: |
| Medications: | Eye Drops: |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |