NAME: ______________________ AGE: ________ DATE: ________________

Home #: ______________ Cell #: ______________ Work #:______________ EMAIL: ___________________________________

Last Eye Exam: ___________ Age of Present Glasses: ____________

Would you like a new fitting or renewal of your contact lens prescription?
YES or **NO** (***additional fees apply***)

Are you ***CURRENTLY*** having any of these problems? If so, please provide detailed information.

PROBLEM	YES	NO	Details
Double Vision			
Drooping Lids			
Dry Eyes			
Flashes of Light			
Floaters			
Foreign Body Sensation			
Headaches			
Irritation			
Itchy Eyes			
Migraines			
Pain			
Photophobia (Light Sensitivity)			
Red Eyes			
Swelling Eye Lid(s)			
Tearing/ Watery			
Visual Field Loss			
Blurred **Distant** or **Near** Vision***(CIRCLE)***			

*Do you **currently** take any **MEDICATIONS** (RX, Vit. or OTC)? YES or NO*
If YES, list meds:

____
____
____

Are you currently using any eye drops?
If YES, list drops: ________________________________

*Do you have **ALLERGIES** to any medications?* ***YES*** or ***NO*** *If **yes**, list meds:*

____
____

*List all **MAJOR ILLNESSES*** (glaucoma, diabetes, high blood pressure, etc.) or **injuries** (concussion, etc.):

____
____

*List any **EYE SURGERIES*** you have had (cataracts, etc.):

____
____

FAMILY HISTORY (Mother, Father, Grandparent, Sibling) Yes NO Unknown
Has any member of your family had these diseases (circle all that apply)?
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis or other heritable disease:

Would you like information about ***LASIK***? **YES** or **NO**

Do you **currently** have any of the following issues? Please specify.	YES	NO	DETAILS
ALLERGIC / IMMUNOLOGIC *(sneezing, swelling, redness, itching, hives, lupus)*			
CARDIOVASCULAR *(high BP, racing pulse)*			
CONSTITUTIONAL/GENERAL *(fever, weight loss or gain, heat stroke, unusually tired)*			
ENDOCRINE *(diabetes, hypothyroid)*			
GASTROINTESTINAL *(stomach upset, diarrhea, constipation, hernia, ulcers)*			
GENITOURINARY/ GENITAL, KIDNEY, BLADDER *(painful urination, frequent urination, yellow jaundice)*			
FEMALES *Are you pregnant? Nursing?*			
EARS / NOSE / THROAT *(hard of hearing, stuffy nose, earache, cough, dry mouth)*			
HEMOTOLOGY / BLOOD / LYMPH *(bleeding, anemia, problems related to blood)*			
INTEGUMENTARY / SKIN *(pimples, warts, growths, rash)*			
MUSCLES, BONES, JOINTS *(Joint pain, stiffness)*			
NEUROLOGICAL *(numbness, headache, seizures, paralysis)*			
PSYCHIATRIC *(anxiety, depression, insomnia)*			
RESPIRATORY *(congestion, wheezing, short of breath)*			

SIGNATURE: ___________________________ DATE: ______________

Doctor's Initials: ______________ Date: ________________