Eye Health History

Patient Name: | Today's Date:

Primary reason for being here today

Last Eye Exam (approx. date) | With Dr.

Do you wear glasses? ❍ Yes ❍ No If Yes, about how old are your glasses?

Do you wear contacts? ❍ Yes ❍ No If Yes, about how old are your contacts?

If yes, what brand or type of contacts do you wear?

Have you had any eye injuries or eye surgeries? ❍ Yes ❍ No If yes, please describe:

Do you have any eye diseases? ❍ Yes ❍ No If yes, please describe:

Do you have any family history of eye diseases? ❍ Yes ❍ No If yes, please describe:

Circle symptoms that apply to you: (Dry Eyes) (Itchy Eyes) (Headaches) (Double Vision) (Eye Pain) (Light Flashes) (Floaters) (Distance blur) (Near Blur) (Poor Color Vision) (Glare)

Please describe any other vision symptoms or problems:

Systemic/General Health History

Primary Care Physician | Name: Date of last visit: ____/____/____

Please list any systemic health issues (Diabetes, High Blood Pressure, etc.):

Family history for systemic diseases: (First degree relatives):

Please list **ALL** medications taken, including prescription and non-prescription, over-the-counter drugs, vitamins, herbal supplements, and eye drops:

Have you ever had any allergies or adverse reactions to *any* medications? ❍ Yes ❍ No *If Yes, please describe*:

Approximate Blood Pressure: ____/____	Approximate Height: _____ ft _____ in	Approximate Weight: _____ lbs

Smoking Status: ❍ Never ❍ Everyday ❍ On occasion ❍ Former smoker: How long ago? _____

Alcohol Use? ❍ None ❍ Social Only ❍ 1-2 daily ❍ 3+ daily ❍ Dependant