Please fill this form out as completely as possible

REASON FOR VISIT
What brings you to our office today?

Are you having any difficulties with your vision/eyes? If so, explain:

Are you currently experiencing any of the following?

Eye itching, Burning, Tearing	Y/N
Dry Eyes	Y/N
Double Vision	Y/N
Eye Pain, Eye Strain, Or Fatigue	Y/N
Flashes of Light in Vision	Y/N
Floaters in Vision	Y/N
Headaches	Y/N

Do you have any special vision needs (i.e. sports, music, hobbies) that you would like the Doctor to be aware of? If so, explain:

OCULAR HISTORY
Approximate Date of Last Eye Exam:

Doctor:

Do you wear glasses? Y/N
For: Distance/Near/Computer/Other

Do you wear contacts? Y/N
If no, would you be interested in wearing contacts? Y/N

Are you interested in Laser Vision Correction? Y/N

Have you had any of the following:

- Eye Surgery Y/N
  If Yes Explain:

- Eye Injury/Head Injury/Stroke Y/N
  If Yes Explain:

- Eye Disease Y/N
  If Yes Explain:

MEDICAL HISTORY
Approximate Date of Last Medical Exam:

Doctor:

General Health: Excellent/Good/Fair/Poor

Do you have problems in any of the following areas?

Allergies, Immune System	Y/N
Sinus, Ears, Nose, Throat	Y/N
Respiratory (Lungs, Breathing, TB)	Y/N
Cardiovascular (Heart, Blood Press)	Y/N
Stomach, Colon	Y/N
Neurological (Seizure, MS)	Y/N
Bones, Joints, Arthritis, Muscles	Y/N
Hepatitis	Y/N
Endocrine (Diabetes, Thyroid)	Y/N
Skin	Y/N
Blood, HIV/AIDS	Y/N
Behavioral, Depression	Y/N
Cancer	Y/N

Please Explain: _____

Current Condition:

Cigarette/Tobacco use?	Y/N
Alcohol use?	Y/N
Other substance(s)?	Y/N
Are you pregnant?	Y/N
Are you nursing?	Y/N

Please list your current medications and why you are taking them (use separate sheet if necessary):

Do you have any allergies to medications? Y/N
(Please indicate the medication and the reaction that occurs)

FAMILY HISTORY
Do any of your blood relatives have problems in the following areas? If yes, who?

Cataracts	Y/N	
Glaucoma	Y/N	
Macular Degen.	Y/N	
Retinal Problems	Y/N	
Blindness	Y/N	
Lazy/Wandering Eye	Y/N	
Diabetes	Y/N	
High Blood Pressure	Y/N	
Cardiovascular	Y/N	
Respiratory	Y/N	
Neurological Disease	Y/N	
Arthritis	Y/N	
Cancer	Y/N	

Doctor Signature: Date: