Name: _____ Date: _____

<u>Eye Conditions:</u> Have you ever been diagnosed with any of the following conditions?

Cataract	**Dry Eye**
Age-related Macular Degeneration	**Eye Infection, inflammation or allergy**
Glaucoma	**Floaters and/or flashes of light**
Diabetes	**Iritis or Uveitis**
Diabetic Retinopathy	**Retinal defects or degenerations**

Please list any additional conditions:

<u>Eye Concerns:</u> Are you having any of the following eye concerns?

Redness	**Itching**	**Discharge**
Burning	**Tearing**	

Please list any additional concerns:

<u>Vision Concerns:</u> Are you having any of the following vision concerns?

Blurred vision	**Severe sensitivity to lights**	**Bothersome night glare**
Eyestrain	**Headache**	**Double vision**
Eye Pain	**Poor night vision**	**Total loss of vision**

Please list any additional vision concerns:

<u>Visual and Occuaptional Function:</u> Please tell us about your current corrective lenses

Current Occupation:_____

Visual and Occupational Function:

Do you currently wear? CL Glasses Neither

Please answer the following with your latest prescription:

Do you have visual difficulty when reading?	Yes	No
Do you have visual difficulty working on a computer?	Yes	No
Do you have visual difficulty at distance?	Yes	No
Do you have problems with night vision or glare?	Yes	No
Do you protect your eyes from sun (UV)?	Yes	No

Review of Systems: Do you have current or past problems with? Explanation of Problem

General/Constitutional: Sudden weight gain or loss, Chronic fever or fatigue, Loss of Appetite, Cancer	Yes	No
Ears/Nose/Mouth/Throat: Hearing Loss, Sinusitis, Dry Mouth, Laryngitis	Yes	No
Neurological: Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor	Yes	No
Psychiatric: Depression, Anxiety	Yes	No
Cardiovascular: Hypertension, Stroke, Heart Disease, Vascular Disease	Yes	No
Respiratory: Cigarette Smoker, Asthma, Bronchitis, Emphysema, COPD	Yes	No
Gastrointestinal: Crohn's Disease, Colitis, Ulcer	Yes	No
Genitourinary: Kidney Disease, Prostrate Disease/Cancer, STD	Yes	No
Musculoskeletal: Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis	Yes	No
Integumentary (Skin): Eczema, Rosacea, Psoriasis	Yes	No
Endocrine: Diabetes, Thyroid dysfunction, Hormonal dysfunction	Yes	No
Hematologic/Lymphatic: Elevated Cholesterol, Anemia, Large Volume Blood Loss, Leukemia	Yes	No
Allergic/Immunologic: Drug Allergies, Environmental Allergies, Rheumatoid Arthritis, Lupus	Yes	No

Medications and Allergies

Do you take any medications? If so please list both prescription and non prescription,	Yes	No
Do you have any allergies? If so please list.	Yes	No

Social History – This information is kept strictly confidential. However if you prefer to discuss directly with the doctor please leave blank.

Use of Alcohol	Yes	No	Rare	Moderate	Excessive
Use of Tobacco	Yes	No	Previous		Current

Family Eye and Medical History:

			Relationship				Relationship
Cataracts	Yes	No		Cancer	Yes	No	
Macular Degeneration	Yes	No		Diabetes	Yes	No	
Glaucoma	Yes	No		Hypertension	Yes	No	
Retinal Detachment/Disease	Yes	No		Thyroid	Yes	No	
Blindness	Yes	No		Elevated Cholesterol	Yes	No	
Crossed Eyes	Yes	No		Heart Disease	Yes	No	

Patient's Signature_________ Date _____

Doctor's Initials Upon Review _____ Date _____