**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Eye Conditions: Have you ever been diagnosed with any of the following conditions?**

**Cataract**

**Age-related Macular Degeneration**

**Glaucoma**

**Diabetes**

**Diabetic Retinopathy**

**Dry Eye**

**Eye Infection, inflammation or allergy**

**Floaters and/or flashes of light**

**Iritis or Uveitis**

**Retinal defects or degenerations**

**Please list any additional conditions:**

**Eye Concerns: Are you having any of the following eye concerns?**

**Redness**

**Burning**

**Itching**

**Tearing**

**Discharge**

**Please list any additional concerns:**

**Vision Concerns: Are you having any of the following vision concerns?**

**Blurred vision**

**Eyestrain**

**Eye Pain**

**Severe sensitivity to lights**

**Headache**

**Poor night vision**

**Bothersome night glare**

**Double vision**

**Total loss of vision**

**Please list any additional vision concerns:**

**Visual and Occuaptional Function: 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_