

Date _____ Patient's Name: Mr/Mrs/Dr/Miss/Ms. _____

Medical History		today	ROS & PFSH		Family Medical History
Do you have now or have you ever had problems related to:					Is there anyone in your family with:
	Yes	No			Yes No Relationship:
Cardiovascular: Heart	<input type="checkbox"/>	<input type="checkbox"/>			Glaucoma <input type="checkbox"/> <input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			Cataracts <input type="checkbox"/> <input type="checkbox"/> _____
Constitutional: Fever	<input type="checkbox"/>	<input type="checkbox"/>			Blindness <input type="checkbox"/> <input type="checkbox"/> _____
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>			Macular Degeneration <input type="checkbox"/> <input type="checkbox"/> _____
Ear, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>			Retinal Detachment <input type="checkbox"/> <input type="checkbox"/> _____
Endocrine: Thyroid	<input type="checkbox"/>	<input type="checkbox"/>			Strabismus (eye turn) <input type="checkbox"/> <input type="checkbox"/> _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			Other Eye Disease <input type="checkbox"/> <input type="checkbox"/> _____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>			Diabetes <input type="checkbox"/> <input type="checkbox"/> _____
Genital, Kidney, Bladder	<input type="checkbox"/>	<input type="checkbox"/>			Heart Disease <input type="checkbox"/> <input type="checkbox"/> _____
Muscles, Bones, Joints	<input type="checkbox"/>	<input type="checkbox"/>			Cancer <input type="checkbox"/> <input type="checkbox"/> _____
Females: Pregnant or Nursing?	<input type="checkbox"/>	<input type="checkbox"/>			High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> _____
Respiratory: Asthma	<input type="checkbox"/>	<input type="checkbox"/>			Medications
Sinus Condition	<input type="checkbox"/>	<input type="checkbox"/>			Are you currently taking: No Name
Loud Snoring	<input type="checkbox"/>	<input type="checkbox"/>			Vitamins <input type="checkbox"/> _____
Obstructive Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>			Oral Contraceptives <input type="checkbox"/> _____
Allergic/Immunologic: Allergies	<input type="checkbox"/>	<input type="checkbox"/>			List all prescription medications:
Neurologic: Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>			name dosage condition treated
Eyes: Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>			_____
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>			_____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>			_____
Vision Therapy	<input type="checkbox"/>	<input type="checkbox"/>			_____
Crossed Eye/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>			_____
Psychiatric: Anxiety, Depression	<input type="checkbox"/>	<input type="checkbox"/>			List any medications that you are allergic to:
Skin: Growths, rashes	<input type="checkbox"/>	<input type="checkbox"/>			_____
Blood Lymph: High Cholesterol/	<input type="checkbox"/>	<input type="checkbox"/>			_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>			If you smoke, use alcohol or controlled substances not prescribed by a physician, describe substance and frequency of use: _____
Adverse Reaction to Eye Drops	<input type="checkbox"/>	<input type="checkbox"/>			_____
Other medical conditions or surgeries and dates: _____					_____

Check the box if you have a problem with, or see any of the following:

<input type="checkbox"/> Burning	<input type="checkbox"/> Redness	<input type="checkbox"/> Sudden loss of vision	<input type="checkbox"/> Seeing at night
<input type="checkbox"/> Sensitivity to light	<input type="checkbox"/> Gritty feeling in eyes	<input type="checkbox"/> Tearing / watery eyes	<input type="checkbox"/> Eye strain
<input type="checkbox"/> Nausea	<input type="checkbox"/> Objects or spots floating in vision	<input type="checkbox"/> Blurry distance vision	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Fainting or dizziness	<input type="checkbox"/> Working up close / reading	<input type="checkbox"/> Itchiness	
<input type="checkbox"/> Flashes of light	<input type="checkbox"/> Dryness	<input type="checkbox"/> Double vision	<input type="checkbox"/> No Problems

Are you currently wearing glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If you wear eyeglasses, please complete the following:</i>
Are you currently wearing contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you interested in thinner, lighter lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you interested in:		Are there times when you would rather not wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No
wearing contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have prescription sunglasses? <input type="checkbox"/> Yes <input type="checkbox"/> No
vision correction by laser surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you bothered by glare or reflections with your glasses, particularly when driving at night? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you spend a lot of time working on a computer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you spend a lot of time outdoors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any problems with your present contact lenses or glasses?		

Patient Signature _____