Patient Medical History

Name of Family Physician ______________________________ Date of Last Physical ________________________
Address ____

CURRENT MEDICATIONS (Rx or Over the Counter)

____
____

Allergies to Medications: ❑ Yes _________________________ ❑ None

Have you ever been diagnosed or treated for the following?

❑ Allergies	❑ Diabetes	❑ Throid
❑ Heart Disease	❑ Asthma	❑ High Blood Pressure
❑ Arthritis	❑ Cancer	❑ Kidney
❑ Cholesterol	❑ Nerves	❑ Other

Patient Eye History

What is the major purpose of this visit?____

Any problems with your present contact lenses or glasses?_______________________________________
Date of Last Eye Exam _________________________ By Whom? ___________________________________

Do you currently wear contact lenses? ❑ Yes ❑ No Have you ever tried contact lenses? ❑ Yes ❑ No
What kind? ____
If you wear contact lenses, are you satisfied with the vision and comfort? ❑ Yes ❑ No
Solutions Used ____
Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? _______________________

Do you……. (Check box if your answer is yes)

❑ ..Work at a computer?
❑ ..Think you might benefit from thinner, lighter lenses?
❑ ..Prefer not to wear your glasses at times?
❑ ..Have interest in a "Test Drive" of the latest contact lens designs
❑ ..Have interest in a non-surgical approach to vision correction?
❑If you wear bifocals, do the lines or head tilting bother you?
❑ ..Spend time outdoors? (How much?) ___hrs/week
❑ ..Have prescription sunglasses?
❑ ..Have more than 1 pair of current Rx glasses?
❑ ..Want information on Laser Vision Correction?
❑ ..Have children?
❑ ..Have family members in need of eyecare?

Is there a family medical history of any of the following?

		Relationship
Blindness	❑	____________________
Cataracts	❑	____________________
Corneal Problems	❑	____________________
Glaucoma	❑	____________________
Lazy Eye	❑	____________________
Macular Degeneration	❑	____________________
Retinal Problems	❑	____________________
Diabetes	❑	____________________
Heart Disease	❑	____________________

Have you ever been diagnosed or treated for the following?

❑ Cataracts	❑ Iritis/Uveitis
❑ Corneal Abrasion	❑ Lazy Eye
❑ Eye infection	❑ Macular Degeneration
❑ Eye injury	❑ Retinal Detachment
❑ Glaucoma	❑ Other eye disorders

Do you experience or have you ever experienced?

❑ Blurry vision	❑ Burning	❑ Sunlight Sensitivity
❑ Burning	❑ Floater/spots	❑ Crossed eye/eye turn
❑ Tearing	❑ Grittiness	❑ Trouble seeing at night
❑ Headaches	❑ Itchiness	❑ Uncomfortable glasses
❑ Flash of light	❑ Double vision	❑ Occasional dryness