VISION AND HEALTH HISTORY

Date: _____

Name:_____ Date of Birth: _____

VISION HISTORY

When was your last eye examination? _____ Examiner: _____

Have you ever worn prescription glasses? No_____ Yes_____

Age of current glasses _____

Does your driver's license indicate you are required to wear glasses to drive? No_____ Yes_____

Class of driver's license: _____

Have you ever worn contact lenses? No_____ Yes_____

Type: _____ Soft contact lenses

_____ Gas permeable contact lenses

_____ Hard contact lenses

Are you interested in wearing contact lenses? No_____ Yes_____

Have you ever done vision training? (Eye exercises / patching) No_____ Yes_____

Occupation:_____

Hobbies:_____

Please estimate your screen time: _____ None

(computer/tablet/phone/laptop) _____ Occasional/ noncontinuous

_____ Moderate (approximately 2 hours per day)

_____ Greater than 2 hours per day

Does your occupation/hobby require safety glasses? No_____ Yes_____

Do you use sun protection for your eyes when outdoors? No_____ Yes_____

Have you ever had:

- Eye surgery? No_____ Yes_____
- Eye injuries? No_____ Yes_____
- Eye infections? No_____ Yes_____
- Complications from contact lens? No_____ Yes_____
- Dry eye? No_____ Yes_____
- Crossed eye (strabismus)? No_____ Yes_____
- Lazy eye (amblyopia)? No_____ Yes_____
- Glaucoma? No_____ Yes_____
- Cataract? No_____ Yes_____
- Retinal detachment? No_____ Yes_____
- Macular degeneration? No_____ Yes_____
- Other vision disorders? No_____ Yes_____

(over)

FAMILY HISTORY

Have your blood relatives (including parents, grandparents, siblings) ever had:

Glaucoma?	No_____ Yes_____
Cataract?	No_____ Yes_____
Retinal detachment?	No_____ Yes_____
Macular degeneration?	No_____ Yes_____
Blindness?	No_____ Yes_____
Other vision disorders?	No_____ Yes_____

MEDICAL HISTORY

Past and present illnesses, as well as medications, can result in visual complaints. Please answer the following questions as accurately as possible.

Family Physician:_____

Have you ever had any of the following:

High blood pressure?	No_____ Yes_____
Heart disorders?	No_____ Yes_____
Diabetes?	No_____ Yes_____
Arthritis?	No_____ Yes_____
Thyroid disorder?	No_____ Yes_____
Stroke?	No_____ Yes_____
Epilepsy?	No_____ Yes_____
Allergies?	No_____ Yes_____
Allergies to medication?	No_____ Yes_____

Other general health concerns: _____

_____

Are you currently a smoker? No_____ Yes_____

Are you a former smoker? No_____ Yes_____

Please list current medications you are using, including eye drops and supplements:

_____

_____

_____

Please tell us how you were referred to this office: _____

I would like a summary report of my examination today sent to my family physician. No_____ Yes_____