PATIENT HISTORY FORM Name_____

Date of last eye exam_____Name of your Primary Care Physician_____

Do you currently wear contacts/glasses_____Are you interested in contact lenses_____

Reason for today's visit_____

_____.

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

_____Blurry vision	_____R _____L Distance or near		
_____Burning	_____R _____L	_____Discharge	_____R _____L
_____Double Vision	_____R _____L	_____Dryness	_____R _____L
_____Excess Tearing/Watering	_____R _____L	_____Eye Infection	_____R _____L
_____Eye Pain or Soreness	_____R _____L	_____Floaters or Spots	_____R _____L
_____Halos	_____R _____L	_____Headaches	_____R _____L
_____Itching	_____R _____L	_____Light Flashes	_____R _____L
_____Light Sensitivity	_____R _____L	_____Redness	_____R _____L
_____Sandy or Gritty Feeling	_____R _____L		

Have you or a family member experienced, or been treated for, any of the following. Circle all that apply.

Cataracts	yes no	family/who_____	Glaucoma	yes no	family/who_____
Macular Degeneration	yes no	family/who_____	Retinal Detachment	yes no	family/who_____
Arthritis	yes no	family/who_____	Asthma	yes no	family/who_____
Blood/Lymph Disorder	yes no	family/who_____	Cancer	yes no	family/who_____
Diabetes	yes no	family/who_____	_____		
High Cholesterol	yes no	family/who_____	Heart Disease	yes no	family/who_____
High Blood Pressure	yes no	family/who_____	Stroke	yes no	family?who_____
Thyroid Problems	yes no	family/who_____			

CURRENT LIST of MEDICATIONS (Prescription and over-the-counter)

_____.

_____.

_____.

_____.

MEDICATION DRUG ALLERGIES

_____.

Are you a smoker? _____ if no, have you ever smoked_____

Are you pregnant or nursing?_____

Please fax, email or bring this completed form with you to your appointment along with your current photo ID, insurance (vision & medical) cards and arrive a few minutes early.