Name:_____ **Birth Date:** ___/___/___ **Sex: M F**

Do you wear glasses? Yes No Contact lenses? Yes No

Have you had eye surgery? What kind?_____ Date:_____

Have you had general surgery? What kind?_____ Date:_____

List all medications/dosage you currently take:_____

List any allergies you have to medications: Medication:_____ Reaction:_____

YOUR EYE HISTORY Do you have or have had any of the following conditions:

Crossed eyes	No	Yes	Diabetic Retinopathy	No	Yes	Macular degeneration	No	Yes
Blepharitis	No	Yes	Dry eye	No	Yes	PVD	No	Yes
Cataract	No	Yes	Eye Injuries	No	Yes	Retinal detachment	No	Yes
Color Blindness	No	Yes	Glaucoma	No	Yes	Other	No	Yes

CURRENT EYE SYMPTOMS Do you have or have had any of the following conditions:

Glare	No	Yes	Burning	No	Yes	Eye pain	No	Yes
Headaches	No	Yes	Dryness	No	Yes	Itching/Sandy/Gritty	No	Yes
Light sensitivity	No	Yes	Tearing	No	Yes	Mucous	No	Yes
Tired eyes	No	Yes	Eyelid swelling	No	Yes	Redness	No	Yes

VISUAL SYMPTOMS Do you have or have had any of the following conditions:

Blur at distance	No	Yes	Flashes of light	No	Yes	Loss of side vision	No	Yes
Blur at near	No	Yes	Floaters/spots	No	Yes	Loss of vision	No	Yes
Distortion	No	Yes	Fluctuation of vision	No	Yes	Other	No	Yes
Double vision	No	Yes	Loss of central vision	No	Yes			

YOUR MEDICAL HISTORY Do you have or have had any of the following conditions:

Fever	No	Yes	Sleep Apnea	No	Yes	Anxiety/depression	No	Yes
Weight loss/gain	No	Yes	Gastrointestinal	No	Yes	Diabetes	No	Yes
Ear/Nose/Throat	No	Yes	Genital/Kidney/Bladder	No	Yes	Thyroid	No	Yes
Heart Problems	No	Yes	Arthritis	No	Yes	Anemia/cholesterol	No	Yes
Hypertension	No	Yes	Rash/Itching/Skin cancer	No	Yes	Allergies (seasonal)	No	Yes
Asthma	No	Yes	MS Headaches	No	Yes	Pregnant	No	Yes

YOUR FAMILY EYE HISTORY Does anyone in your family have or have had any of the following conditions:

Lazy eye	No	Yes	Eye tumors	No	Yes	Macular degeneration	No	Yes
Cataracts	No	Yes	Glaucoma	No	Yes	Retinal detachment	No	Yes
Color blindness	No	Yes	Glaucoma suspect	No	Yes	Strabismus/eye turn	No	Yes

YOUR FAMILY MEDICAL HISTORY Does anyone in your family have or have had any of the following conditions:

Arthritis	No	Yes	High blood pressure	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Kidney disease	No	Yes	Thyroid disease	No	Yes
Diabetes	No	Yes	Lupus	No	Yes	Other	No	Yes
Heart disease	No	Yes						

SOCIAL HISTORY Married Yes No Occupation_____

Do you use tobacco products? Yes No If yes, how many packs/cigars per day:_____

Do you drink alcohol? Yes No If yes, how many drinks per day:_____