REASON FOR VISIT

Check all that apply:

Pain ◯ Blur ◯ Double Vision ◯ Headache ◯ Redness ◯ Itchiness ◯ Dryness ◯ Spots ◯

Other:_____

Which eye?
Right ◯
Left ◯
Both ◯

Severity
Mild ◯
Moderate ◯
Severe ◯

Duration: for how long have you been experiencing these symptoms?
Please include any additional info you think may be helpful:

_____

_____

EYE HEALTH & MEDICAL HISTORY

Date of Last Eye Exam: _____ Do you wear glasses? Yes/No Fulltime ◯ Reading ◯ Distance ◯

Do you wear contacts? Yes/No Fulltime ◯ Part-time ◯ Sports ◯ Other ◯ Brand/Power of Contacts: _____

List all current or past eye diseases, eye injuries, or eye surgeries: _____

Current Eye Drops: _____ Hobbies: _____

Physician's Name: _____ Allergies to medications: _____

Pharmacy/Location: _____

Medications you're currently taking:

_____

Tobacco Use? Yes/No Alcohol Use? Yes/No Are you currently pregnant? Yes/No

Please check appropriate box below if you or a family member have any of the following:

	Self	Family		Self	Family
Shingles	◯	◯	High blood pressure	◯	◯
Seizures	◯	◯	Elevated cholesterol	◯	◯
Stroke	◯	◯	Heart disease	◯	◯
Anxiety	◯	◯	Heart attack	◯	◯
Depression	◯	◯	Sinusitis	◯	◯
Diabetes	◯	◯	Asthma	◯	◯
Thyroid Disorder	◯	◯	Allergies	◯	◯
Anemia	◯	◯	Emphysema	◯	◯
Blood Disorder	◯	◯	Headaches	◯	◯
Lupus	◯	◯	Cancer	◯	◯
Epilepsy	◯	◯	Other:_____		
Parkinson's	◯	◯			
Alzheimer's	◯	◯			