PATIENT HEALTH INFORMATION

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Doctor's Initials

Name of Family Doctor ______________________________ **Date of Last Visit** _______________

Date of Last Eye Exam _____________ Where? _________________________ Dilated? ______

Do you wear Glasses? Y/N   Do you wear Contact Lenses? Y/N   **If yes, for what purpose?**

Near (Reading) Y/N   Intermediate (Computer) Y/N   Distance (Driving) Y/N

Have you experienced or been diagnosed with any of the following? ***PLEASE CIRCLE Y OR N***

Blurred Vision	Y N	Glaucoma	Y N
Circle: One / Both Distance / Near		Cataracts	Y N
Frequent Headaches	Y N	**High Blood Pressure**	Y N
Dry Eyes	Y N	**Diabetes**	Y N
Burning In or Around Eyes	Y N	Type/Date ______________________	
Seeing Black, Floating Spots	Y N	Other Eye Conditions	Y N
Seeing Flashes of Light	Y N	Explain ________________________	
Cloud or Curtain cover part of Vision	Y N	Eye Surgery/Injury	Y N

Have you had any operations? Y N Type: _________________________ When? __________

Do you use Cigarettes/Tobacco? ________ Alcohol? _________ Other Substance(s)? _________

Additional Information ____

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Current Medication	**Reason (HBP, Diabetes, Etc.)**
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________

FAMILY HEALTH HISTORY

High Blood Pressure Y N Relation _____________ Diabetes Y N Relation _____________

Glaucoma Y N Relation _____________ Macular Degeneration Y N Relation ___________

Cataracts Y N Relation _____________ Retinal Detachment Y N Relation ___________

Other eye Condition(s) Y N What Kind? _________________________ Relation ___________

INITIAL AND DATE - ONLY ONCE PER YEAR

I have reviewed this form and the above information accurately reflects my current medical and eye heath history.

Patient Initials ____________ Date _____________   Patient Initials ____________ Date _____________

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