EYE HISTORY				MEDICAL HISTORY			
Date of Last Eye Exam				Date of Last Physical			
Optometrist/Ophthalmologist				Primary Doctor			
Currently Wear Glasses	5?	Yes	No				
Currently Wear Contacts?		Yes No		Have you been diagnosed			
Brand				or treated for the following?			
Powers: Right				AIDS/HIV	yes	no	
Left				Allergies	yes	no	
Reason for Today's Visit?				Arthritis	yes	no	
				Asthma	yes	no	
				Blood/Lymph	yes	no	
				Cancer	yes	no	
Have you or a family member been diagnosed				Diabetes	yes	no	
or treated for the following?				Ears, Nose, Throat	yes	no	
Cataracts	yes	no		Gastrointestinal	yes	no	
Glaucoma	yes	no		Heart Disease	yes	no	
Lazy Eye	yes	no		Hypertension	yes	no	
Macular Degeneration	yes	no		High Cholesterol	yes	no	
Retinal Detachment	yes	no		Kidney Disease	yes	no	
Eye Surgeries	yes	no	describe	Lupus	yes	no	
				Neurological	yes	no	
				Psychiatric Disorder	yes	no	
				Skin Conditions	yes	no	
Are any of these symptoms a current concern?				Stroke	yes	no	
Blurry Vision distanc	e arms lei	ngth rea	ıding	Thyroid Dysfunction	yes	no	
Burning		Halos		pregnant currently	yes	no	
Discharge		Headach	ies				
Double Vision Itching			Current Medications (prescription and over the counter)				
Dryness Light Flashes							
Excess Tearing/Watering	ng	Light Ser	nsitivity				
Eye Infection Redness							
Eye Pain or Soreness Sandy or Gritty Feeling			Medication Drug Allergies				
Floaters or Spots							
	Do	vou parti	cipate in ANY of	the following Activitie	es?		
Arts/Crafts	Competitive Sports			Running		<u> </u>	
Biking	Driving			Snow Sports	_	Water Sports	
Computer	Golfing			Video Games	11310. 2 p0.10		

Reading

Date _____

Name ______

Hunting

Music