

PATIENT HEALTH HISTORY

PATIENT NAME _____ DATE _____

EYE HEALTH HISTORY

NAME OF EYE DOCTOR _____ PHONE _____

DO YOU CURRENTLY WEAR glasses contacts how long _____ yrs neither

DO YOU HAVE VISUAL DIFFICULTY WHEN READING? Y N

DO YOU HAVE VISUAL DIFFICULTY WHEN DRIVING? Y N

HAVE YOU EVER HAD EYE SURGERY? Y N

If yes-please describe _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING EYE CONDITIONS? (circle yes or no)

Glaucoma	Y	N	_____	Redness	Y	N	_____
Cataracts	Y	N	_____	Itching	Y	N	_____
Eye Injury	Y	N	_____	Burning	Y	N	_____
Poor Night Vision	Y	N	_____	Dryness	Y	N	_____
Lazy Eye	Y	N	_____	Discharge	Y	N	_____
Eye Pain	Y	N	_____	Drooping Eyelid	Y	N	_____
Blurred Vision	Y	N	_____	Crusting on Eyelid	Y	N	_____
Decreased Vision	Y	N	_____	Floating dark spots on eyes	Y	N	_____
Flashes of Light	Y	N	_____	Sandy/gritty sensation	Y	N	_____
Glare: Day or Night	Y	N	_____	Foreign body sensation	Y	N	_____
Halos: Day or Night	Y	N	_____	Retinal tear or detachment	Y	N	_____
Light Sensitivity	Y	N	_____	Other			_____

SOCIAL HISTORY

DO YOU SMOKE? Y N Frequency _____

DO YOU DRINK ALCOHOL? Y N Frequency _____

DO YOU USE DRUGS? Y N Frequency _____

MEDICAL HEALTH HISTORY

ARE YOU CURRENTLY BEING TREATED FOR ANY OF THE FOLLOWING?

cardio vascular disease diabetes high blood pressure
 rheumatoid arthritis stroke other _____

LIST ALL SURGICAL PROCEDURES YOU HAVE HAD _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING _____

LIST ALL KNOWN DRUG ALLERGIES _____

