Patient History Form

When was your **last eye exam**? _____

Who is your **Primary Care Physician**? _____

Please check the following **Medical conditions** you currently have, or have had in the past:

☐ Diabetes ☐ Thyroid ☐ High Cholesterol ☐ Autoimmune diseases

☐ Cancer ☐ Asthma ☐ Heart conditions ☐ Hypertension

☐ Headaches/Migraines

Are you Pregnant or Nursing? Y / N

Please check the following **Ocular conditions/complaints** you currently have, or have had in the past:

☐ Blurred vision – Distance and/or Near

☐ Glaucoma	☐ Cataracts	☐ Nevus	☐ Flashes
☐ Bell's Palsy	☐ Floaters	☐ Dry eyes	☐ Tearing
☐ Itching	☐ Burning	☐ Pain	☐ Strain
☐ Glare	☐ Red eyes	☐ Lazy eye	☐ Double vision
☐ Keratoconus	☐ Retinal conditions	☐ Macular Degeneration	

Any history of eye injuries or surgeries? _____

List your **current Medications**: _____

_____

Allergies: _____

Glasses History: ☐ Distance ☐ Near ☐ Progressives ☐ Bifocals

Comments/complaints: _____

Contact Lens History:

Brand & Prescription: _____

Replacement schedule: ☐ Daily ☐ Biweekly ☐ Monthly ☐ Quarterly ☐ Yearly

Comments/complaints: _____

Please check the following Medical and Ocular conditions in your **Family History**:

☐ Diabetes	☐ Hypertension	☐ High Cholesterol	☐ Autoimmune disease
☐ Cataracts	☐ Glaucoma	☐ Heart conditions	☐ Macular Degeneration
☐ Lazy eye	☐ Blindness	☐ Retinal Detachment	☐ Retinitis Pigmentosa