

Patient Name: _____

Date: _____

List any **MEDICATIONS** you take now. Include all non-prescription drugs & vitamins.

Name of Medicine	Strength	How Many?	Times a day?	Reason for taking
1				
2				
3				
4				
5				
6				
7				

Are you **ALLERGIC** to **SULFA**? (Please check) No Yes

Are you **ALLERGIC** to any medications? (Please check) No Yes; if yes please list:

1. _____ 2. _____
 3. _____ 4. _____

ALLERGIC to: Kidney or Heart dye? (Please Check) No Yes Iodine? No Yes Shellfish? No Yes

Any major **ILLNESS** or injuries? (Please check) No Yes; If yes, please list:

1. _____ 2. _____
 3. _____ 4. _____

Any major **SURGERIES**? (Please check) No Yes; If yes, please list:

1. _____ 2. _____
 3. _____ 4. _____
 (date) (date)

Your **EYE HISTORY** (Check yes or no; if yes, please explain) Do you have any problems with:

- Glare/ Halo No Yes _____
- Headaches No Yes _____
- Tired eyes No Yes _____
- Amblyopia (lazy eye) No Yes _____
- Burning No Yes _____
- Excess tearing / watering No Yes _____
- Eye pain or soreness No Yes _____
- Foreign body sensation No Yes _____
- Infection of the eye / lid or styel No Yes _____
- Itching No Yes _____
- Mucous discharge No Yes _____
- Drooping eyelid No Yes _____
- Redness No Yes _____
- Sandy or gritty feeling No Yes _____
- Strabismus (crossed or turned) No Yes _____
- Blurred distance vision No Yes _____
- Blurred near vision No Yes _____
- Distorted Vision or halos No Yes _____
- Double vision No Yes _____
- Floater / spots No Yes _____
- Fluctuating vision No Yes _____
- Loss of vision No Yes _____
- Loss of side vision No Yes _____

(OVER)

Patient Name _____

Date _____

Your Medical History (please check yes or no; if yes explain)

- Autoimmune (lupus/ rheumatoid arthritis/ Sjögren's, etc.) No Yes _____
- Cystic Fibrosis in yourself/ or exposure to a Cystic Fibrosis person (S) No Yes _____
- Take steroid/ immunosuppression medicine No Yes _____
- Currently pregnant or planning No Yes _____
- Prior history of Herpes in the eye No Yes _____
- Skin (Keliod, eczema, rosacia, psoriasis) No Yes _____
- Endocrine (diabetes, hypothyroid, etc.) No Yes _____
- Allergic/ immunologic (lupus, etc.) No Yes _____
- Ear/Nose/Throat (sinus/ dry mouth, etc) No Yes _____
- Heart (blood pressure/ cholesterol, etc.) No Yes _____
- Respiratory (asthma/ emphysema, etc. No Yes _____
- Gastrointestinal (ulcers/ diarrhea, etc.) No Yes _____
- Neurological (stroke, multiple sclerosis) No Yes _____
- Psychiatric (anxiety, depression, etc.) No Yes _____
- Blood/ Lymph (cholesterol, anemia, etc.) No Yes _____
- Viral (HIV, Hepatitis A, B or C, etc.) No Yes _____

FAMILY EYE & MEDICAL HISTORY (PLEASE CHECK YES OR NO; IF YES, PLEASE EXPLAIN& LIST RELATIONSHIP TO PATIENT)

- Diabetes No Yes Relationship _____
- Lupus No Yes Relationship _____
- Amblyopia (lazy eye) No Yes Relationship _____
- Blindness No Yes Relationship _____
- Cataracts No Yes Relationship _____
- Color Blindness No Yes Relationship _____
- Glaucoma No Yes Relationship _____
- Macular Degeneration No Yes Relationship _____
- Retinal Detachment No Yes Relationship _____
- Strabismus (crossed or turned eye) No Yes Relationship _____
- Arthritis No Yes Relationship _____
- Cancer No Yes Relationship _____
- Heart Disease No Yes Relationship _____
- High blood pressure No Yes Relationship _____
- Kidney disease No Yes Relationship _____
- Stroke No Yes Relationship _____
- Thyroid No Yes Relationship _____
- Other _____

Social History

- Do you drive a car? • No • Yes _____
- Do you have problems with night vision? • No • Yes _____
- Have you ever tried contact lenses? • No • Yes _____
- Do you currently wear contact lenses? • No • Yes Since _____
- How many hours/day? _____ How many days/weeks? _____ When last worn? _____
- Do you wear glasses? • No • Yes Since _____ • Full time • Part time • Distance • Close
- Glasses owned? • Single Vision • Trifocals • Safety • Progressive • Bifocals • Back-up
- Sports • Other: _____
- Have you had trouble in the past with glasses? • No • Yes If yes, please explain _____
- Have you had trouble in the past with bifocals? • No • Yes If yes please explain _____
- Do you wear sunglasses? • No • Yes Are your sunglasses prescription? • No • Yes
- Do you drink alcohol? • No • Yes • Occasional • 1 per day • 2-3 per day • 4+ per day
- Do you smoke? • No • Yes • Occasional • ½ pack per day • 1 pack per day • 1+ per day