Name: ______________________________ Date: ______________

Date of Last Eye Exam: ___________ Currently Wear: ❑ Eyeglasses ❑ Contact Lenses ❑ Sunglasses

Type of Contact Lenses: ______________________________

Special Vision Needs or Hobbies: ______________________________

Primary Care Physician/Office Information: ______________________________

____

____

Medications: ______________________________

____

Allergies to Medications: ______________________________

Other Allergies: ______________________________

Height: _____ft ______in Weight: __________ lbs

Check the following conditions that apply to you:

❑ Eye Injury or Infection	❑ Diabetes	❑ Skin Condition	❑ Fever
❑ Eye Surgery	❑ High Blood Pressure	❑ Weight Change	❑ Cancer
❑ Dry Eye	❑ High Cholesterol	❑ Stomach/Gastrointestinal	❑ HSV
❑ Lazy Eye or Eye Turn	❑ Multiple Sclerosis	❑ Immune Deficiency	❑ Arthritis or Joint
❑ Cataracts	❑ Thyroid	❑ Lung or Respiratory	❑ Asthma
❑ Macular Degeneration	❑ Headaches	❑ Ear/Nose/Throat	❑ Blood Disorder
❑ Retinal Detachment	❑ Pregnant or Nursing	❑ Kidney or Liver	❑ HIV
❑ Glaucoma	❑ Heart Conditions	❑ Psychological	❑ Head Injury

❑ Alcohol Use: type & amount: ______________________________

Tobacco Use: ❑ Never ❑ Past ❑ Current; amount: ______________________________

Please provide details for any of above conditions and add any other health conditions not listed:

____

____

Check the following conditions that apply to family members and list relationship:

❑ Glaucoma ______________	❑ Diabetes ______________
❑ Cataracts ______________	❑ High Blood Pressure ______________
❑ Macular Degeneration ______________	❑ Heart Disease ______________
❑ Retinal Detachment ______________	❑ Thyroid Condition ______________
❑ Other Eye Conditions ______________	❑ Other Systemic Conditions ______________