VISION AND HEALTH HISTORY Date: ____________________

Name: ______________________________________ Date of Birth: ____________________

VISION HISTORY:

When was your last eye examination? _______________ Examiner:_______________

Have you ever worn prescription glasses? No _____ Yes _____
Age of current glasses ___________________________

Does your driver's license indicate you are required to wear glasses to drive?
No _____ Yes _____
Class of driver's license: _____
Have you ever worn contact lenses? No _____ Yes _____

Type: __________ Soft contact lenses
__________ Gas permeable contact lenses
__________ Hard contact lenses

Are you interested in wearing contact lenses? No _____ Yes _____

Have you ever done vision training? (Eye exercises/ patching)
No _____ Yes _____

Occupation: ____
Hobbies: ____

Please estimate your computer use: ___________ None
___________ Occasional/ noncontinuous
___________ Moderate (approx. 2h/ day)
___________ Greater than 2 hours per day

Does your occupation / hobby require safety glasses? No _____ Yes _____

Do you use sun protection for your eyes when outdoors? No _____ Yes _____

Have you ever had:
- Eye surgery? No _____ Yes _____
- Eye injuries? No _____ Yes _____
- Eye infections? No _____ Yes _____
- Complications from contact lens? No _____ Yes _____
- Dry eye? No _____ Yes _____
- Crossed eye (strabismus)? No _____ Yes _____
- Lazy eye (amblyopia)? No _____ Yes _____
- Glaucoma? No _____ Yes _____
- Cataract? No _____ Yes _____
- Retinal detachment? No _____ Yes _____
- Macular degeneration? No _____ Yes _____
- Other vision disorders? No _____ Yes _____

Name: ______________________________________

Date: ______________________________________

FAMILY HISTORY: Have your blood relatives (including parents, grandparents, siblings) ever had:

Glaucoma?	No _____	Yes _____
Cataract?	No _____	Yes _____
Retinal detachment?	No _____	Yes _____
Macular degeneration?	No _____	Yes _____
Blindness?	No _____	Yes _____
Other vision disorders?	No _____	Yes _____

MEDICAL HISTORY:

Past and present illnesses, as well as medications, can result in visual complaints.

Please answer the following questions as accurately as possible.

Family physician: ______________________________

Have you ever had any of the following:

High blood pressure?	No _____	Yes _____
Heart disorders?	No _____	Yes _____
Diabetes?	No _____	Yes _____
Arthritis?	No _____	Yes _____
Thyroid disorder?	No _____	Yes _____
Stroke?	No _____	Yes _____
Epilepsy?	No _____	Yes _____
Allergies?	No _____	Yes _____
Allergies to medication?	No _____	Yes _____

Other general health concerns: ______________________________________

____

Are you a smoker or former smoker? No _____ Yes _____

Please list current medications you are using, including eye drops and supplements:

____

____

Please tell us how you were referred to this office: ____________________

I would like a summary report of my examination today sent to my family physician. No _____ Yes _____