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Eye & Medical History

Full Name _____ ***Today's Date*** _____

Reason for today's exam? _____

Referring Doctor? _____

When was your last complete eye exam? _____ Doctors Name _____

Do you wear glasses? **YES** **NO**

Do you wear contact lenses? **YES** **NO**

Pharmacy Name & Number: _____

Do you need cataract surgery? **YES** **NO**

Doctor's Name _____

When was your last physical exam? _____

GENERAL HEALTH:

___Allergies
___Asthma/Pulmonary
___Diabetes
___Heart Disease
___Drug Sensitivities
___Skin Conditions
___Thyroid Conditions
___High Blood Pressure
___Low Blood Pressure
___Fainting
___Surgical Operations
___Pregnant
___Seizures
___Do you smoke? **YES** **NO**
___Other (Specify) _____

OCULAR HEALTH:

___Macular Degeneration ___Family Hx
___Glaucoma Family Hx
___Cataracts Family Hx
___Eye Surgery
___Eye or head injuries
___Turned or crossed eye
___Flashes of light
___Floaters
___Other (specify) _____

VISUAL SYMPTOMS:

___Blur at distance
___Blur at near
___Eye strain
___Headaches
___Glare
___Rereading Words
___Losing place while reading
___Sensitivity to bright light
___Double Vision
___Eyes itch, burn, get red or tear

History of Stroke **YES** **NO**

COVID vaccine? (2 doses) **YES** **NO**

When? _____ EKG _____

Weight (lbs): _____ Height: _____

If you have diabetes who is your endocrinologist? _____

Are you presently taking medication? **Yes** **NO**
If Yes, Please list _____

Are you allergic to any medications? **YES** **NO** If Yes, Please list

_____