Patient Name:_____ Date:_____

What are your goals for today's visit?_____

Circle:
_____ New glasses New contacts

When was your last exam?_____

Do you wear Eyeglasses? Full time Part time Distance Near Computer Multifocal Sun

Do you wear Contact Lenses? Soft Hard/RGP Full time Part Time

Are you experiencing any of the following symptoms? Blurred vision: Distance Near Intermediate/Computer
Burning Itching Discharge Dryness Watering Eyes/Tearing Redness Flashes
Floaters Eyestrain Headaches Double Vision Pain Hard to see in dim light/poor night vision Glare
Other:_____

Do you have any of the following Eye Conditions: Amblyopia/lazy eye Strabismus/eyeturn Glaucoma
Cataract Macular Degeneration Dry Eye Other:_____

Please list any eye injuries you have had:_____

Please list any eye surgeries you have had:_____

Do you have any of the following medical problems?

Allergies	Hypertension	Shingles
Arthritis	High Cholesterol	Skin Disorder
Asthma	Kidney disorder	Tuberculosis
Cancer (type_____)	Lupus	Thyroid Disorder High Low
Diabetes (type_____)(last A1C_____)	Migraines	Sinus Problems
Depression	Prostate Disease	Sleep Apnea
Heart Disease	Psychiatric Disorder	Spinal Disorder

Other Medical Problems:_____

Do you use tobacco products now? Yes No

List all medications you are take on a regular basis, including over the counter: (Or give us a copy of your med list)

Medication	Strength	How Often?	What for?

Do you have any medication allergies?_____ Other Allergies?_____

Does anyone in your family have:
Glaucoma: Who?_____
Cataract: Who?_____
Macular degeneration: Who?_____
Hypertension: Who:_____
Diabetes: Who:_____

Other eye or medical disorders run in your family?:_____