NAME:_____ DATE:_____

PRIMARY CARE DOCTOR _____ADDRESS:_____

MOST BOTHERSOME <u>EYE</u> COMPLAINT:_____

WHEN WAS YOUR LAST EYE EXAM?_____DOCTOR:_____

<u>VISION HISTORY:</u> Have you ever had?

(YES)	(NO)	
_____	_____	Amblyopia (lazy eye)
_____	_____	Eye Injury
_____	_____	Prior Eye Surgery
_____	_____	Eye "Laser" Treatment
_____	_____	Glaucoma
_____	_____	Cataract
_____	_____	Retinal Disorder
_____	_____	Double Vision
_____	_____	Glasses (Since Age _____)
_____	_____	Dry Eyes
_____	_____	Eye Infections
_____	_____	Other (_____)

<u>HEALTH HISTORY:</u> Have you ever had?

_____	_____	High blood pressure
_____	_____	Diabetes
_____	_____	Arthritis
_____	_____	Heart Disease
_____	_____	Asthma
_____	_____	Cancer
_____	_____	Stroke
_____	_____	Neurological Disease
_____	_____	Hospitalizations
_____	_____	Head Injuries
_____	_____	Problems with Anesthesia
_____	_____	Surgery
_____	_____	Keloid Healer (Scar easily)
_____	_____	Bleeding Disorder
_____	_____	Autoimmune Disease
_____	_____	Other (_____)

<u>OTHER HISTORY:</u>

(YES)	(NO)	
_____	_____	Are you currently Pregnant or Nursing?_____
_____	_____	Are you allergic to any medications?_____
_____	_____	Do you have any other allergies?_____
_____	_____	Do you have Hayfever?

When was your blood pressure last checked?_____
When was your cholesterol last checked?_____
Do you smoke?_____How much?_____

<u>FOR OFFICE USE</u>

CURRENT EYE MEDICATIONS:

CURRENT OTHER MEDICATIONS: