Date of Last Medical Exam: ____________________ Doctor's Name/Clinic: ________________________________

Date of Last Eye Exam: ________________________ Doctor's Name/Clinic: _______________________________

Were you planning on getting glasses today? (Yes/No) Contacts? (Yes/No)

Do you wear glasses? (Yes/No) Frequency: All the time/Sometimes/Work Only/Reading only/Driving only

How old are your present glasses? ________________________ Do you wear prescription sunglasses? (Yes/No)

Do you wear contacts? (Yes/No) Type: _________________________ Solution Used: __________________

Contact wearing schedule: Daily/Overnight Replacement schedule: Daily/2-week/Monthly/Yearly

Have you ever had eye injuries? (Yes/No) Which eye? ____________________________________

Have you ever used eye medication? (Yes/No) Why? ____

Are you currently pregnant or nursing? Yes/No/Not Applicable

Visual Symptoms: Indicate right eye/left eye/both.

[ ] (R L B) Blurred Vision (Far)	[ ] (R L B) Dry Eyes	[ ] (R L B) Headaches	[ ] (R L B) Seeing Flashes
[ ] (R L B) Blurred Vision (Near)	[ ] (R L B) Red Eyes	[ ] (R L B) Migraine Headaches	[ ] (R L B) Seeing Halos
[ ] (R L B) Double Vision	[ ] (R L B) Watery Eyes	[ ] (R L B) Sandy/Gritty Feeling	[ ] (R L B) Loss of Vision
[ ] (R L B) Eye Strain/Tired Eyes	[ ] (R L B) Burning Eyes	[ ] (R L B) Poor Color Vision	[ ] (R L B) Wandering Eye
[ ] (R L B) Eye Infections	[ ] (R L B) Itchy Eyes	[ ] (R L B) Poor Night Vision	[ ] (R L B) Light Sensitive
[ ] (R L B) Eye Pain/Soreness	[ ] (R L B) Mucus Discharge	[ ] (R L B) Floaters or Spots	[ ] (R L B) Droopy Eyelid

Current Medications: Please list any current medications/drugs (including herbal): **See attached list? ____**

Medication	**Reason**	**Medication**	**Reason**
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	

Past Medical History: Have you ever had any of the following? Please circle Y or N.

Ocular	**Medical**
• Glaucoma (Y/N) • Cataracts (Y/N) • Macular degeneration (Y/N) • Surgery (Y/N) Why? __________________________ ____	• Hypertension/High blood pressure (Y/N) • Diabetes (Y/N) • Other: ____________________________________ ____ ____

Family History: Has anyone in your family had any of the following? Please circle Y or N and specify the relation.

Ocular	**Medical**
• Glaucoma (Y/N) _________________________________ • Cataracts (Y/N) _________________________________ • Macular degeneration (Y/N) _______________________	• Hypertension/High blood pressure (Y/N) ____ • Diabetes (Y/N) _________________________________

Turn over ➔

Review of Systems: Please check if any of the following currently apply to you.
(If none apply, please check "None.")

Allergic/Immunologic:	**Eyes:**	**Musculoskeletal:**	**Cardiovascular:**
___ *None* ___ Drug allergy: ____________________ ___ Environmental allergy: ____________________ ___ Rheumatoid arthritis ___ Lupus ___ Other:	___ *None* ___ Glaucoma ___ Cataracts ___ Macular degeneration ___ Surgery ___ Inflammatory disorders ___Blurred vision ___Double vision ___ Other:	___ *None* ___ Fibromyalgia ___ Muscular dystrophy ___ Osteoarthritis ___ Ankylosing spondylitis ___ Other:	___ *None* ___ Heart disease ___ Hypertension/High blood pressure ___ Stroke ___ Vascular disease ___ Other:
Gastrointestinal: ___ *None* ___ Crohn's disease ___ Colitis ___ Ulcer ___ Digestive ___ Other:	**Neurological:** ___ *None* ___ Multiple sclerosis ___ Epilepsy ___ Alzheimer's disease ___ Parkinson's disease ___ Cerebrovascular ___ Other:	**Constitutional:** ___ *None* ___ Developmental disability ___ Weight loss ___ Fever ___ Fatigue ___ Trauma ___ Other:	**Genitourinary:** ___ *None* ___ STD, viral herpetic, chlamydia ___ Other:
Psychiatric: ___ *None* ___ Depression ___ Panic disorder ___ Schizophrenia ___ Other:	**Ears/Nose/Mouth/Throat:** ___ *None* ___ Upper respiratory tract infection ___ Ear ache ___ Runny nose ___ Sore throat ___ Ear ringing/tinitis ___ Other:	**Hematologic/Lymphatic:** ___ *None* ___ Anemia ___ Large-volume blood loss ___ Leukemia ___ Other:	**Respiratory:** ___ *None* ___ Cigarette/cigar smoker ___ Asthma ___ Bronchitis ___ Emphysema ___ Other:
Endocrine: ___ *None* ___ Non-insulin-dependent diabetes ___ Insulin-dependent diabetes ___ Thyroid problem ___ Hormonal dysfunction ___ Other:	**Integumentary:** ___ *None* ___ Eczema ___ Rosacea ___ Psoriasis ___ Other:	**Height:** **Weight:** **BP:**	**Alcohol Use:** (Yes/No) Amount: **Tobacco Use:** (Yes/No) Amount:

Please list physical reactions to allergies listed above ____
____
____

- - - - - The following is for office use only - - - - -

Reviewed by: Dr. Dolezal | Dr. Cannon

Doctor's Signature: ____ Date (mm/dd/yyyy): ___________________