Personal Eye Information

When was your last eye exam?

If you wear glasses/contacts, please list your current Rx/brand of contacts/how old your glasses are:

If you wear contacts, do your eyes feel irritated when wearing contacts? Yes □ No □

Please indicate if you have any of the following conditions:

□ Dry Eyes □ Glaucoma □ Cataracts □ Macular Degeneration
□ Crossed/Lazy Eye □ Diabetic Retinopathy □ Blurry Vision □ Double Vision
□ Floaters □ Flashes □ Itch or Gritty Eyes
□ Retinal Diseases or Detachment

□ Other: ____

Have you ever had eye surgery? Yes □ No □
If yes, what kind of surgery (explain): ____
Have you ever had your eyes dilated before? Yes □ No □
Have you ever had an eye injury? Yes □ No □
If yes, describe: ____

Please list any eye drops you are currently using including over the counter drops (Visine, Clear Eyes, Refresh, etc.)

Medical History

Please indicate if you have and/or are taking medication for any of the following conditions:

□ High Blood Pressure □ Diabetes □ High Cholesterol □ Cardiovascular
□ Skin □ Ear/Nose/Throat □ Allergies □ Headaches
□ Gastrointestinal □ Nervous □ Endocrine (glands) □ Urinary
□ Blood/Lymph □ Muscles/Bones □ Respiratory □ Psychiatric
□ Pregnancy □ None

Do you currently smoke or have a history of smoking? □Yes □No
If yes, how often do you smoke or when did you quit? ___________________________
Do you drink Alcohol? □Yes □No

Please list all medications you are taking:

Please list any allergies you have including allergies to medication:

Name of family doctor and/or primary care physician:

Date of last visit:

Family History

Please indicate if anyone in your family has the following conditions:

□ High Blood Pressure Relation:________________ □ Diabetes Relation:_________________
□ Macular Degeneration Relation:________________ □ Glaucoma Relation:_________________
□ Retinal Detachment Relation:________________ □ Cataracts Relation:_________________