Name: ______________________________ Date of Birth: _________________

Reason for eye exam today: ____

Pharmacy Name: _________________________________

Primary Care Physician's name: _________________________

Previous Eye Doctor's name(s):___________________________ Date of last eye exam: ______________

Do you wear contact lenses? No Yes (If Yes, what type? Gas Permeable Soft- replaced every ______ days)

Do you experience any of the following currently with your vision? (Please check all that apply.)

- ☐ Blurred distance
- ☐ Blurred near
- ☐ Burning
- ☐ Itchiness
- ☐ Headaches
- ☐ Tearing
- ☐ Dryness
- ☐ Eye strain
- ☐ Reading problems
- ☐ Glare with bright lights
- ☐ Floaters/ Spots
- ☐ Soreness
- ☐ Flashes of light
- ☐ Redness
- ☐ Double vision
- ☐ Sudden loss of vision
- ☐ Sensitivity to light

Tobacco Use: No Yes If so, what type and for how long?________________________________

Alcohol Use: No Yes If so, how much and how often? _________________________________

Eye History:

Do you have, or have you had in the past any of the following:

- ☐ Glaucoma
- ☐ Eye Surgery
- ☐ Eye Infection
- ☐ Eye Disease
- ☐ Eye Injury
- ☐ Cataracts
- ☐ Lazy Eye
- ☐ Other: ____________________________________

- ☐ Any other eye concerns or history that we should be aware of: ___________________________________

  ____

  ____

Family Medical History: (Relationship of family member with condition)

Glaucoma ____

Cataracts ____

Diabetes ____

Hypertension ____

Lazy Eye ____

Macular Degeneration ____

Other eye or medical problems ____

____

____

Personal Medical History/Conditions (Please check all that apply. IF NORMAL, CHECK NONE.)

Constitutional
- ☐ Good General Health
- ☐ Recent Weight gain/loss
- ☐ Fever/Fatigue
- ☐ Other: ________________

Immune/Allergy
- ☐ NONE
- ☐ Environmental Allergy
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ HIV
- ☐ Tuberculosis
- ☐ Other: ________________

Respiratory
- ☐ NONE
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sarcoidosis
- ☐ Tuberculosis
- ☐ Other: ________________

Blood/Lymph
- ☐ NONE
- ☐ Anemia
- ☐ History of large blood loss
- ☐ Bleeding disorder
- ☐ Other: ________________

Ear/Nose/Throat
- ☐ NONE
- ☐ Sinus
- ☐ Hearing Loss
- ☐ Other: ___________________

Gastrointestinal
- ☐ NONE
- ☐ Ulcers
- ☐ Gall Bladder disease
- ☐ Inflammatory disease
- ☐ Hepatitis
- ☐ Other: _________________

Genitourinary
- ☐ NONE
- ☐ Kidney Problems
- ☐ Prostate
- ☐ Other: ________________

Endocrine
- ☐ NONE
- ☐ Diabetes
- ☐ Thyroid
- ☐ Menopause
- ☐ Other: ________________

Cardiovascular
- ☐ NONE
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Other: ________________

Nervous System
- ☐ NONE
- ☐ Multiple Sclerosis
- ☐ Head Injury
- ☐ Seizures/Convulsions
- ☐ Other: ________________

Musculoskeletal
- ☐ NONE
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Cold Extremities
- ☐ Other: _____________

Psychiatric
- ☐ NONE
- ☐ ADHD/Hyperactivity
- ☐ Depression
- ☐ Memory Loss/Confusion
- ☐ Schizophrenia
- ☐ Other: _____________

Other Conditions not already marked:
- ☐ NONE
- ☐ Cancer(s):____________

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  ____
- ☐ Developmental Disorder
- ☐ Loss of Consciousness
- ☐ Other: _____________

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Past Eye Surgeries or Eye Injuries

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Other Past Surgeries

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Office Use: Reviewed/updated

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