

NAME:

| PERSONAL HISTORY: DATE | | | | UpDate | UpDate | UpDate |
|--|--|---------------------------|---------------------------|------------------|--------|--------|
| Visual needs: Occupational and Hobbies | | (Circle yes or no) | | | | |
| Do you need safety glasses for power tools, firearms, or work? | | NO | YES | | | |
| Do you have sunglasses needs for reading, sports, boating? | | NO | YES | | | |
| Do you use a computer, have detail hobbies at close distance? | | NO | YES | | | |
| Do you currently have any of the following problems: | | | (Circle yes or no) | | | |
| Eye dryness (burning, irritation, tearing) | | NO | YES | explain | | |
| Eye allergies (itching, redness, irritation) | | NO | YES | explain | | |
| Chronic fever, unexpected weight loss/gain, fatigue | | NO | YES | explain | | |
| Ear/nose/throat problems (sinusitis, ear infections) | | NO | YES | explain | | |
| Heart problems (chest pains, irregular beat) | | NO | YES | explain | | |
| Respiratory problems (wheezing, coughing) | | NO | YES | explain | | |
| Gastrointestinal problems (heartburn, diarrhea) | | NO | YES | explain | | |
| Urinary problems (pain, discomfort) | | NO | YES | explain | | |
| Skin problems (rashes, dryness, rosacea) | | NO | YES | explain | | |
| Musculoskeletal problems (aches, joint pain, swelling) | | NO | YES | explain | | |
| Neurologic problems (numbness, headaches) | | NO | YES | explain | | |
| Psychiatric diagnosis (depression, anxiety, bipolar) | | NO | YES | explain | | |
| Do you smoke? | | NO | YES | how Much? | | |
| Do you drink alcohol? | | NO | YES | How Much? | | |
| Have you ever had surgery or been hospitalized | | NO | YES | explain | | |
| Are you currently pregnant or nursing | | NO | YES | Which Trimester? | | |
| Do you have family members with eye diseases | | NO | YES | explain | | |
| | | | | | | |

NAME:

Medical History & Review (Circle yes or no) Update Update Update

| | | |
|-----------------------------|----|-----|
| Diabetes Type 2 or juvenile | NO | YES |
| High blood pressure | NO | YES |
| Heart cardiovascular | NO | YES |
| Auto-immune | NO | YES |
| Arthritis | NO | YES |
| Joint pain | NO | YES |
| Cholesterol | NO | YES |
| Thyroid | NO | YES |
| Cancer | NO | YES |

| | | | |
|-------------------------------|-----|---|--|
| Eye History and Review | | (Circle yes or no) and provide details | |
| Previous Eye Surgeries | NO | YES | |
| Lasik or refractive surgery | NO | YES | |
| Contact lens use | NO | YES | |
| Cataracts | NO | YES | |
| Retinal Detachment | NO | YES | |
| Macular degeneration | NO | YES | |
| Glaucoma | NO | YES | |
| Prex IOP | IOP | | |
| Pachy | | | |
| Gonio | | | |
| C/D | | | |

| | | | |
|----------------------------|--|------------------|--|
| Current physician | | Last Seen | |
| Previous Eye Doctor | | Last Seen | |

List All Medications, vitamins, herbs, and birth control medications: or provide RX list

| | | | |
|---|--|--|--|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |

LIST All Allergies to medications or other

| | | | |
|---|--|--|--|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |

Confidentially given by:

Date: