# EYECARE HISTORY

## 1 Name_____

Date of last eye exam? _____

Name of eye doctor _____

Do you wear glasses? ❑ Yes ❑ No

❑ All the time ❑ Occasionally

❑ Reading ❑ Driving ❑ TV

Do you wear contacts? ❑ Yes ❑ No

Type_____ Hours/Day _____

Describe any problems you have with your contacts _____

_____

_____

_____

Place a mark on the box to indicate if you have had any of the following:

| | | | |
|---|---|---|---|
| Eye Surgery | ❑ | Floaters or Spots | ❑ |
| Blurred Vision – Distance | ❑ | Glaucoma | ❑ |
| Blurred Vision – Near | ❑ | Headaches | ❑ |
| Burning Eyes | ❑ | Itching Eyes | ❑ |
| Cataracts | ❑ | Light Sensitive | ❑ |
| Color Vision, Poor | ❑ | Loss of Vision | ❑ |
| Crossed Eyes | ❑ | Migraine Headaches | ❑ |
| Discharge from Eyes | ❑ | Night Vision, Poor | ❑ |
| Dizzy Spells | ❑ | Red Eyes | ❑ |
| Double Vision | ❑ | Seeing Halos | ❑ |
| Dry Eyes | ❑ | Seeing Flashes | ❑ |
| Eye Infection | ❑ | Temporary Loss of Vision | ❑ |
| Eye Injury | ❑ | Twitching Eyelid | ❑ |
| Eye Strain | ❑ | Vision Poor | ❑ |
| Fainting Spells, Blackouts | ❑ | Watering Eyes | ❑ |

## 2 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on the box to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

| | Yourself | Family Members | | Yourself | Family Members |
|---|---|---|---|---|---|
| AIDS/HIV | ❑ | ❑ | Heart Condition | ❑ | ❑ |
| Arthritis | ❑ | ❑ | Hepatitis (Type_____) | ❑ | ❑ |
| Artificial Heart Valve | ❑ | ❑ | High Blood Pressure | ❑ | ❑ |
| Artificial Joints | ❑ | ❑ | Lazy Eye | ❑ | ❑ |
| Asthma | ❑ | ❑ | Macular Degeneration | ❑ | ❑ |
| Blood/lymph disease | ❑ | ❑ | Mental Health | ❑ | ❑ |
| Blindness | ❑ | ❑ | Musculoskeletul | ❑ | ❑ |
| Cancer | ❑ | ❑ | Nervous system | ❑ | ❑ |
| Cardiovasculor disease | ❑ | ❑ | Pacemaker | ❑ | ❑ |
| Cataracts | ❑ | ❑ | Poor Color Vision | ❑ | ❑ |
| Chemical Dependency | ❑ | ❑ | Retinal Disease | ❑ | ❑ |
| Diabetes | ❑ | ❑ | Respiratory Disease | ❑ | ❑ |
| Ears, Nose, Throat | ❑ | ❑ | Skin Conditions | ❑ | ❑ |
| Emphysema | ❑ | ❑ | Stroke | ❑ | ❑ |
| Endocrine (glands) | ❑ | ❑ | Thyroid Conditions | ❑ | ❑ |
| Eye Surgery | ❑ | ❑ | Tuberculosis | ❑ | ❑ |
| Gastrointestinal | ❑ | ❑ | Turned Eye | ❑ | ❑ |
| Genitourinary | ❑ | ❑ | | | |
| Glaucoma | ❑ | ❑ | | | |
| Hay Fever | ❑ | ❑ | | | |

Are you pregnant?_____ Number of Children _____

Tobacco use _____ Alcohol Use _____

Drug Abuse _____

## 3 ALLERGIC TO

NONE ❑_____

_____

_____

_____

## 4 CURRENT MEDICATIONS

NONE ❑_____

_____

_____

_____

## 5 PAST SURGICAL PROCEDURES
other than above

NONE ❑ _____

_____

_____

_____

_____

## 6 PAST SIGNIFICANT MEDICAL DIAGNOSIS
other than above

NONE ❑ _____

_____

_____

_____

_____

## 7 SIGNIFICANT FAMILY HEALTH HISTORY
other than above

NONE ❑ _____

_____

_____

_____

_____

## 8 SIGNIFICANT FAMILY EYE HISTORY
other than above

NONE ❑ _____

_____

_____

_____

_____

## 9 WOULD LIKE TO DISCUSS

❑ **Occupational Glasses**

❑ **Reading Glasses**

❑ **Sunglasses**

❑ **Safety Glasses**

❑ **Sport Glasses**

❑ **Music Glasses**

❑ **Second pair discount**

❑ **Contact Lenses**

❑ **Low Vision Aids**

❑ **Other**

_____

_____

_____

## 10 SIGNATURE/DATE

**Update: Date** _____ **Signature** _____

**Date** _____ **Signature** _____

**Date** _____ **Signature** _____

**Date** _____ **Signature** _____

**Date** _____ **Signature** _____

**Date** _____ **Signature** _____