

4 HEALTH HISTORY

Please circle Y for YES or N for NO to indicate if you have had any of the following.

High Blood Pressure	Y	N	High Cholesterol	Y	N
Diabetes	Y	N	Thyroid Condition	Y	N
Cancer	Y	N	Kidney Disease	Y	N
Allergies	Y	N			

List any other known conditions _____

List all medications you are taking (include dosage and any "over-the-counter" medications) _____

List any allergies to medication _____

Who is your primary care physician? (Please provide your doctor's *first and last* name) _____

List the names of any additional medical specialists _____

Date of your last physical _____

What is the name of your Medical Insurance carrier? _____

5 EYE HISTORY

Please circle Y for YES or N for NO to indicate if you have had any of the following. Also, if a blood relative has had any of the following conditions, circle Y or N and indicate their relationship to you (such as parent, siblings, children, etc)

	Yourself		Family Members		Relationship
Macular Degeneration	Y	N	Y	N	_____
Cataracts	Y	N	Y	N	_____
Glaucoma	Y	N	Y	N	_____
Dry Eyes	Y	N	Y	N	_____
Retinal Detachment	Y	N	Y	N	_____
Flashes of Light/Floaters					

Have you had ANY type of eye surgery? _____ if yes, please describe the type of surgery, which eye, approximate date and the surgeons name _____

Do you have headaches? _____ If yes, how often? _____

Location of pain _____ Duration of pain _____

Have you ever worn glasses? Y N Have you ever worn contact lenses? Y N

Do you wear glasses now? Y N Do you wear contact lenses now? Y N

So that we can best apply exam findings to eyewear needs, please answer the following questions.

When was your last eye exam? _____ By whom? _____

Do you work on a computer? _____ If yes, how many hours per day? _____

Are you experiencing eyestrain? _____

List your hobbies, sports, and special interests _____