Patient Medical/Eye History

Name____ Date__/__/______

Reason for today's visit: ____

Date of <u>last</u> eye exam: ___/___/___

Currently taking any ***medications***, including eye drops, vitamins and supplements (If yes, please list below, or provide a list if available):____

____

Medication allergies or sensitivities: ____
Environmental allergies or sensitivities: ____

Are you considering Lasik or other refractive surgery in the near future? ______________________

Are you interested in enhancing or changing your eye's natural color? ________________________

Do you wear glasses? __________ Do you wear contact lenses? (if yes, which brand)____________

Do <u>YOU</u> have a history of:

Eye Surgery____________ Flashes/Floaters____________ Headaches on a regular basis____________

Light/Glare Sensitivity____________ Eyes Itch____________ Eyes Burn__________ Eye Pain________

For <u>YOU</u> or any <u>BLOOD RELATIVE</u>, is there a history of: (<u>*PLEASE INDICATE WHO*</u>)

Glaucoma____________ Cataracts____________ Macular Degeneration____________

Retinal Disease or Detachment____________ Crossed/Lazy Eye____________ Diabetes____________

Hypertension____________ Heart Disease____________ Thyroid_____________ Arthritis___________

High Cholesterol____________ Sinus Problems____________ Multiple Sclerosis____________

Asthma/Respiratory Disease____________ Systemic Lupus____________ Crohn's Disease____________

Other Immune System Conditions____________ Bladder/Kidney Disease____________

Migraines____________ Seizures____________ Anxiety____________ Depression____________

Bleeding/Anemia____________ Cancer____________ HIV/AIDS____________ Other____________

Are you currently?

__Pregnant or Nursing **__Current Smoker** **__Former Smoker** **__Do you Drink Alcohol**