

Patient Medical/Eye History

Name _____ Date ___/___/___

Reason for today's visit: _____

Date of last 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 YOU have a history of:

Eye Surgery _____ Flashes/Floaters _____ Headaches on a regular basis _____

Light/Glare Sensitivity _____ Eyes Itch _____ Eyes Burn _____ Eye Pain _____

For YOU or any BLOOD RELATIVE, is there a history of: (PLEASE INDICATE WHO)

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