Medical History

Name: ______________________ **Today's Date:** ______________

Date of Birth: ______________________ **Primary Care Doctor:** ______________

Pharmacy: ______________________ **Date of last eye exam:** ______________

Do you wear glasses? Readers? (if yes, how old are they)? ______________________

Do you have any drug and/or food allergies? ______________________

Please list or provide a list of current medications (prescription and/or over the counter):

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Demographics:

Height? ________	Do you drive?	Yes No	Ladies, are you currently pregnant?	Yes No
Weight? ________	Smoke?	Yes No	Nursing?	Yes No

Family History

Please circle if anyone in your family has been diagnosed with the following:

Lazy Eye	Yes	No	Relation:	Crossed Eyes	Yes	No	Relation:
Blindness	Yes	No	Relation:	Cancer	Yes	No	Relation:
Cataract	Yes	No	Relation:	Diabetes	Yes	No	Relation:
Glaucoma	Yes	No	Relation:	Heart Disease	Yes	No	Relation:
Macular Degeneration	Yes	No	Relation:	Hypertension	Yes	No	Relation:
Retina Disease	Yes	No	Relation:				

Are you currently experiencing or have a history of any of the following? Please circle Yes or No.

Double Vision	Yes	No	Itching/Burning	Yes	No	Anemia	Yes	No
Distorted Vison	Yes	No	Watering	Yes	No	Lupus	Yes	No
Flashes of Light	Yes	No	Redness	Yes	No	Cancer	Yes	No
Floaters	Yes	No	Eye Pain	Yes	No	Stroke	Yes	No
Glare	Yes	No	Tired Eyes	Yes	No	Asthma	Yes	No
Blurred Vision	Yes	No	Bumps on Lids	Yes	No	COPD	Yes	No
Light Sensitivity	Yes	No	Foreign Body Sensation	Yes	No	Hypertension	Yes	No
Hearing Loss	Yes	No	Depression/Anxiety	Yes	No			
Sinus Problems	Yes	No	Headaches	Yes	No			
Seasonal Allergies	Yes	No	Autism	Yes	No			
Numbness	Yes	No	Epilepsy Seizures	Yes	No			
Heart Problems	Yes	No	Kidney/Bladder Problems	Yes	No			
Skin Problems	Yes	No	Muscle aches/joint pain/swollen joints	Yes	No			
Diabetes (type 1 or 2)	Yes	No	Thyroid Problems (hypo/underactive or hyper/overactive)	Yes	No			

***Any other specific health issue not listed above?**

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Please list any major surgeries you have had:

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Contact Lens Wearers

What brand of contacts do you wear? ______________ Age of current pair? ______________

How often do you throw them away? ______________ Do you sleep in your contacts? ______________

Doctor's Signature: ______________________ **Date:** ______________