Patient Name:_____ Date:_____

List any **MEDICATIONS** you take now. Include all non-prescription drugs & vitamins.

| Name of Medicine | Strength | How Many? | Times a day? | Reason for taking |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |

Are you **ALERGIC** to **SULFA**? (Please check) □ No □ Yes

Are you **ALLERGIC** to any medications? (Please check) □ No □ Yes; if yes please list:

1._____ 2. _____

3 ._____ 4._____

**ALLERGIC** to: Kidney or Heart dye? (Please Check) □ No □ Yes Iodine? □ No □ Yes Shellfish? □ No □ Yes

Any major **ILLNESS** or injuries? (Please check) □ No □ Yes; If yes, please list:

1. _____ 2. _____

3. _____ 4. _____

Any major **SURGERIES**? (Please check) □ No □ Yes; If yes, please list:

1. _____ _____ 2. _____ _____

3 ._____ _____ 4. _____ _____

(date) (date)

Your **EYE HISTORY** (Check yes or no; if yes, please explain) Do you have any problems with:

| | | |
|---|---|---|
| Glare/ Halo | □ No | □ Yes_____ |
| Headaches | □ No | □ Yes_____ |
| Tired eyes | □ No | □ Yes_____ |
| Ambloyopia (lazy eye) | □ No | □ Yes_____ |
| Burning | □ No | □ Yes_____ |
| Excess tearing / watering | □ No | □ Yes_____ |
| Eye pain or soreness | □ No | □ Yes_____ |
| Foreign body sensation | □ No | □ Yes_____ |
| Infection of the eye / lid or stye | □ No | □ Yes_____ |
| Itching | □ No | □ Yes_____ |
| Mucous discharge | □ No | □ Yes_____ |
| Drooping eyelid | □ No | □ Yes_____ |
| Redness | □ No | □ Yes_____ |
| Sandy or gritty feeling | □ No | □ Yes_____ |
| Strabismus (crossed or turned) | □ No | □ Yes_____ |
| Blurred distance vision | □ No | □Yes_____ |
| Blurred near vision | □ No | □ Yes_____ |
| Distorted Vision or halos | □ No | □ Yes_____ |
| Double vision | □ No | □ Yes_____ |
| Floaters / spots | □ No | □ Yes_____ |
| Fluctuating vision | □ No | □ Yes_____ |
| Loss of vision | □ No | □ Yes_____ |
| Loss of side vision | □ No | □ Yes _____ |

**(OVER)**

Patient Name_____ Date_____

## Your Medical History (please check yes or no; if yes explain)

| | | | |
|---|---|---|---|
| ●Autoimmune **(**lupus/ rheumatoid arthritis**/ Sjögren's,** etc.) | □ No | □Yes | _____ |
| ●Cystic Fibrosis **in yourself/ or exposure to a Cystic Fibrosis person (S**) | ℞No | ℞Yes | _____ |
| ●Take steroid/ immunosupression medicine | □No | □Yes | _____ |
| ●Currently pregnant or planning | □No | □Yes | _____ |
| ●Prior history of Herpes in the eye | □No | □Yes | _____ |
| ●Skin (Keliod, eczema, rosacia, psoriasis) | □No | □Yes | _____ |
| ●Endocrine (diabetes, hypothyroid, etc.) | □No | □Yes | _____ |
| ●Allergic/ immunologic (lupus, etc.) | □No | □Yes | _____ |
| Ear/Nose/Throat (sinus/ dry mouth, etc) | □No | □Yes | _____ |
| Heart (blood pressure/ cholesterol, etc.) | □No | □Yes | _____ |
| Respiratory (asthma/ emphysema, etc. | □No | □Yes | _____ |
| Gastrointestinal (ulcers/ diarrhea, etc.) | □No | □Yes | _____ |
| Neurological (stroke, multiple sclerosis) | □No | □Yes | _____ |
| Psychiatric (anxiety, depression, etc.) | □No | □Yes | _____ |
| Blood/ Lymph (cholesterol, anemia, etc.) | □No | □Yes | _____ |
| Viral (HIV, Hepatitis A, B or C, etc.) | □No | □Yes | _____ |

## FAMILY EYE & MEDICAL HISTORY (PLEASE CHECK YES OR NO; IF YES, PLEASE EXPLAIN& LIST RELATIONSHIP TO PATIENT)

| | | | |
|---|---|---|---|
| ●Diabetes | □No | □Yes | Relationship _____ |
| ●Lupus | □No | □Yes | Relationship _____ |
| Amblyopia (lazy eye) | □No | □Yes | Relationship _____ |
| Blindness | □No | □Yes | Relationship _____ |
| Cataracts | □No | □Yes | Relationship _____ |
| Color Blindness | □No | □Yes | Relationship _____ |
| Glaucoma | □No | □Yes | Relationship _____ |
| Macular Degeneration | □No | □Yes | Relationship _____ |
| Retinal Detachment | □No | □Yes | Relationship _____ |
| Strabismus (crossed or turned eye) | □No | □Yes | Relationship _____ |
| Arthritis | □No | □Yes | Relationship _____ |
| Cancer | □No | □Yes | Relationship _____ |
| Heart Disease | □No | □Yes | Relationship _____ |
| High blood pressure | □No | □Yes | Relationship _____ |
| Kidney disease | □No | □Yes | Relationship _____ |
| Stroke | □No | □Yes | Relationship _____ |
| Thyroid | □No | □Yes | Relationship _____ |
| Other | | | _____ |

## Social History

Do you drive a car? • No • Yes Any visual difficulty when driving? • No • Yes_____

Do you have problems with night vision? • No • Yes Do you have glare problems? • No • Yes

Have you ever tried contact lenses? • No • Yes Reason for stopping_____

Do you currently wear contact lenses? • No • Yes Since_____

How many hours/day? _____ How many days/weeks? _____ When last worn? _____

Do you wear glasses? • No • Yes Since_____ • Full time • Part time • Distance • Close

Glasses owned? • Single Vision • Trifocals • Safety • Progressive • Bifocals • Back-up
• Sports • Other: _____

Have you had trouble in the past with glasses? • No • Yes If yes, please explain_____

Have you had trouble in the past with bifocals? • No • Yes If yes please explain_____

Do you wear sunglasses? • No • Yes Are your sunglasses prescription? • No • Yes

Do you drink alcohol? • No • Yes • Occasional • 1 per day • 2-3 per day • 4+ per day

Do you smoke? • No • Yes • Occasional • ½ pack per day • 1 pack per day • 1+ per day