Reason for today's exam? _____

Date and reason for last eye exam? _____

Are you allergic to any medications? YES ☐ NO ☐ If yes, please list: _____

Please list all the medicine(s) you are currently taking with mg(s) and dose: _____

_____

Do you currently wear glasses? YES ☐ NO ☐ Type _____
Do you currently wear contacts? YES ☐ NO ☐ Type _____
Have you had a recent weight loss or appetite change? YES ☐ NO ☐
Do you bruise or bleed easily? YES ☐ NO ☐
Have you ever been treated for depression or anxiety? YES ☐ NO ☐

Do you have any problems with the following?

	YES	NO		YES	NO		YES	NO
SKIN			EARS			NOSE		
THROAT			STOMACH/DIGESTION			KIDNEYS/BLADDER		
MUSCLE/BONES			HEART			LUNGS		
HEADACHES			NUMBNESS			PARALYSIS		
OTHER								

Please check all the following that currently apply to you:

	YES	NO		YES	NO		YES	NO
MIGRAINES			PREGNANCY			VISION LOSS		
ARTHRITIS			HIV/AIDS					
SMOKE/DRINK			IF YES, HOW MUCH?					
PREVIOUS SURGERIES	YES	NO	IF YES, PLEASE LIST ALL					

Have you ever had any of the following eye conditions?

	YES	NO		YES	NO		YES	NO
EYE SURGERY			EYE LASERS			EYE INJURY		
DOUBLE VISION			EYE INFECTION/DISCHARGE			FLOATERS/FLASHING LIGHTS		
EYE ALLERGIES			DRY EYES			CATARACT'S		
MACULAR DEGENERATION			SEVERE EYE PAIN					
OTHER								

Do you or your family have a history of the following? If so Whom?

	YES	NO	IF YES, WHOM
DIABETES			
BLINDNESS			
HIGH BLOOD PRESSURE			
GLAUCOMA			
THYROID CONDITION			
LAZY EYE			
CROSSED EYE			
HEART DISEASE			
BREATHING DIFFICULTIES			
TUBERCULOSIS			
KERATOCONUS			
MARFAN'S SYNDROME			
RETINAL DETACHMENT			
IV DRUG USE			
OTHER			