Eye Health History:

Date of your last eye exam: _____ Physician's Name: _____

(Please circle yourself or a blood relative has had any of the following conditions.)

YOURSELF

- *Arthritis*
- *Asthma*
- *Blindness*
- *Cancer*
- *Cataracts*
- *Diabetes*
- *Drug Sensitivity*
- *Emphysema*
- *Epilepsy*
- *Eye Surgery*
- *Glaucoma*
- *Hay Fever*
- *HIV/AIDS*
- *High Blood Pressure*
- *Lazy Eye*
- *Lupus*
- *Macular Degeneration*
- *Migraine Headaches*
- *Poor Color Vision*
- *Retinal Disease*
- *Shingles*
- *Stroke*
- *Thyroid Conditions*
- *Turned Eye*

FAMILY MEMBERS

- *Arthritis*
- *Asthma*
- *Blindness*
- *Cancer*
- *Cataracts*
- *Diabetes*
- *Drug Sensitivity*
- *Emphysema*
- *Epilepsy*
- *Eye Surgery*
- *Glaucoma*
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- *Lazy Eye*
- *Lupus*
- *Macular Degeneration*
- *Migraine Headaches*
- *Poor Color Vision*
- *Retinal Disease*
- *Shingles*
- *Stroke*
- *Thyroid Conditions*
- *Turned Eye*

Do you wear glasses: yes / no

How often do you wear them? All the time / Occasionally / Reading / Driving / TV / Never

Do you wear contact lenses: yes / no

Type: _____ Manufacturer: _____

Replacement Schedule:_____ Hours Per Day: _____

Do you have any problems/concerns in regards to your contact lenses? Please list below:

Please list any medications you are currently taking, including any eye drops or herbal supplements:

_____
_____
_____
_____
_____
_____
_____
_____

Please list any allergies you have to medications or other substances:

_____
_____
_____
_____
_____
_____
_____
_____

Reveiwed By:

_____ Date_____
(Physician's Signature)