



Patient Health Information

Patient Name _____

Date _____

Reason for today's visit _____

Please check below:

- I am interested in wearing contact lenses
- I would like more information on surgery that may reduce my need for glasses or contact lenses
- I am interested in surgical correction of Cataracts Glaucoma

Are you having any of the symptoms below:

- | | | | | | |
|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|---|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision with glasses | <input type="checkbox"/> | <input type="checkbox"/> | Eye Pain R___ L___ How long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Halos or glare | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal sensitivity to light |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty reading | <input type="checkbox"/> | <input type="checkbox"/> | Scratchy eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty reading street signs | <input type="checkbox"/> | <input type="checkbox"/> | Itchy eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor side vision | <input type="checkbox"/> | <input type="checkbox"/> | Mattering |
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision | <input type="checkbox"/> | <input type="checkbox"/> | Crusting |
| <input type="checkbox"/> | <input type="checkbox"/> | Flashes in vision | <input type="checkbox"/> | <input type="checkbox"/> | Excessive tearing |
| <input type="checkbox"/> | <input type="checkbox"/> | Night blindness | <input type="checkbox"/> | <input type="checkbox"/> | Headaches Location: _____ How long? _____ |

Other, please list: _____

Do **YOU PERSONALLY** have a history of any of the conditions listed below:

- | | | | | | | | | |
|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|------------------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> | Other stomach ailments |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Breathing problems | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer Type: _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Please check if there is any **FAMILY** history of:

- Glaucoma Retina Disease Other, please list: _____
- Cataracts Diabetes

List all medications you are currently taking, including over the counter medications: _____

What eye drops are you currently using? _____

Are you allergic to any medications? Please list: _____

Please list any previous eye surgeries or injuries to the eye: _____

Do you smoke? _____ How much and how long? _____

Do you drink alcohol? _____ Amount and frequency? _____

Are you pregnant? _____

Present visual correction: Glasses: Bifocal Trifocal Reading

Contact lenses: Rigid gas permeable Soft Disposable Toric Bifocal

Are you pleased with your current prescription? Yes No If No, why? _____

Patient Signature

Tech Initials