

Eye Health History

Physician's Name: _____

Do you wear contacts? YES NO

Date of Last Visit: _____

Type: _____

Date of Last Eye Exam: _____

Hours/Day: _____

Name of Doctor: _____

Do you wear glasses? YES NO

Have you had any issues with your contacts?
Please Describe.

How often?

All the time Occasionally

Reading Driving

Eye Health History Continued

Place a mark on "Yes" or "No" to indicate if you have any of the following:

Bloodshot Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision-- Distance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision-- Near	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Color Vision-- Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discharge from Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Vision-- Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Infection, Injury, Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos or Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells, Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Watering Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Health History

Physician's Name: _____ Date of Last Visit: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Member	
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	No _____
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco Use? <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol Use? <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Allergies?</u>
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Medications?</u>
Type: _____			_____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Skin Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Turned Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____