Visual Health/History Form

Name_______________________________________Date_______________________________________

Current Job or Year in School ______________________ Hobby __________________________

Main Reason for today's visit

____

____

____

Please check all that apply:

__Dry __Burning __Stinging __Red __Sandy/gritty__Itchy __Mucous ___Tearing

Do you work on a computer? Y/N How many hours/day? ______________________________

Last Eye Exam was _______________Eye Doctor's Name ________________________________

Date of Last Physical _______ Primary Care Dr. ________________ at _____________________

Medications:

____

____

Allergy to Medications: ____

Do you have hayfever/seasonal allergies/food allergies? _______________________________

Do you wear glasses? Y/N

Do you wear Contact Lenses? Y/N

Have you had:

Injuries/hard blows to head or eyes? ____

Any sudden loss of vision?____

Do you see Flashes of Light? Y/N or Floaters? Y/N

Do you see Double? Y/N

Have you had eye surgery ever? Y/N Please List:____

____

Tobacco Use? Y/N Quit? Y Packs/Day ________________

Alcohol Use? Y/N/Only Rarely How many drinks/day? _________________

Recreational Drugs? Y/N/Rarely May we ask what kind?_____________________________

List any physical diseases or conditions:

FOR YOURSELF

Y / N	Y / N	Y /N
__ __ Blindness	__ __ Diabetes	__ __ Arthritis
__ __ Cataracts	__ __ High Blood Pressure	__ __ Thyroid Disease
__ __ Glaucoma	__ __ Stroke	__ __ Kidney Disease
__ __ Macular Degeneration	__ __ High Cholesterol	__ __ Cancer/Tumors
__ __ Headaches	__ __ Asthma/Emphysema	__ __ Psychiatric
__ __ Hepatitis	__ __ HIV/AIDS	

Other____

FAMILY MEMBERS (parents, siblings, aunts, uncles, grandparents)

Y / N	Y / N	Y /N
__ __ Blindness	__ __ Diabetes	__ __ Arthritis
__ __ Cataracts	__ __ High Blood Pressure	__ __ Thyroid Disease
__ __ Glaucoma	__ __ Stroke	__ __ Kidney Disease
__ __ Macular Degeneration	__ __ High Cholesterol	__ __ Cancer/Tumors
__ __ Headaches	__ __ Asthma/Emphysema	__ __ Psychiatric
__ __ Hepatitis	__ __ HIV/AIDS	

Other____

DURING YOUR EYE EXAM YOU MAY EXPERIENCE BLURRINESS OF THE PRINT, EVEN DOUBLE VISION AT TIMES. THESE ARE PART OF THE TESTING PROCEDURE. PLEASE TRY TO RELAX AND NOT WORRY ABOUT MAKING MISTAKES/WRONG ANSWERS AND HAVE FUN WITH THE EXAM!