

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Dr: \_\_\_\_\_

**Chief Complaint:**

**History of Present Illness:**

Location / Severity / Timing / Modifying factors / Quality / Duration / Context / Associated signs and symptoms: Brief (1-3) / Extended (4-8)

Do Not Write

Contact Lens Wear	
Soft:	Daily Wear
	Toric
	Extended Wear
Hard:	RGP
	PMMA
Current Rx:	_____ x _____
	_____ x _____
Avg. Wearing Time	_____
Date Last Worn	_____

**DO NOT WRITE ABOVE THIS LINE**

**Prior eye problems**

- What doctor last examined your eyes? Dr. \_\_\_\_\_
- When was your last eye exam? \_\_\_\_\_ How old are your current glasses? \_\_\_\_\_
- Please **CIRCLE** each of the following.
  - No - **Cataract surgery:** Yes (give dates): Right eye \_\_\_\_\_ Left eye \_\_\_\_\_
  - No - **Laser surgery:** Yes (give dates): Right eye \_\_\_\_\_ Left eye \_\_\_\_\_
  - No - **Retinal detachment:** Yes (give dates): Right eye \_\_\_\_\_ Left eye \_\_\_\_\_
  - No - **Glaucoma:** Yes - Date diagnosed \_\_\_\_\_ Glaucoma surgery \_\_\_\_\_
  - No - **Eye injury:** Yes - Which eye? \_\_\_\_\_ Type of trauma and treatment? \_\_\_\_\_
  - No - **Lazy eye:** Yes - Which eye? \_\_\_\_\_ Did your eye turn in or out? \_\_\_\_\_ Date of surgery \_\_\_\_\_
  - No - **Other eye surgeries:** Yes - \_\_\_\_\_
  - No - **Other:** \_\_\_\_\_

**Medical History & Review of Systems:** Please **CIRCLE** each of the following

- No - **Constitutional:** Yes - Fever / Weight loss / Weight gain
- No - **Diabetes:** Yes - YEAR DIAGNOSED \_\_\_\_\_. TREATED WITH (circle all that apply): Diet / Pills / Insulin  
 What type of diabetes do you have: Type 1 / Type 2 / Don't know  
 What was your last: Glucose: \_\_\_\_\_ (Date: \_\_\_\_\_) Hemoglobin A1C: \_\_\_\_\_ (Date: \_\_\_\_\_)
- No - **Endocrine problems:** Yes - Thyroid / Other:
- No - **High blood pressure:** Yes
- No - **Hearing problems:** Yes
- No - **Heart problems:** Yes - Irregular heart beat / Chest pain / Heart failure / Angina / Heart attack / Bypass surgery
- No - **Lung problems:** Yes - Breathing problems / Asthma / Bronchitis / Emphysema / Other:
- No - **Gastrointestinal problems:** Yes - Nausea / Diarrhea / Ulcers / Hepatitis / Crohn's disease / Other:
- No - **Kidney problems:** Yes - Urinary problems / Stones / Failure / Dialysis / Other:
- No - **Arthritis:** Yes - Joint pains / Degenerative arthritis / Rheumatoid arthritis / Other:
- No - **Neurologic problems:** Yes - Seizure / Headaches / Migraines / Other:
- No - **Mental health conditions:** Yes - Depression / Schizophrenia / Other:
- No - **Blood problems:** Yes - Anemia / Bleeding problems / Clotting problems / Sickle cell / Other:
- No - **HIV / AIDS:** Yes - \_\_\_\_\_
- No - **Skin problems:** Yes - \_\_\_\_\_
- No - **Cancer:** Yes (Include type, date, and treatment) \_\_\_\_\_
- No - **Surgery:** Yes (Include type & date) \_\_\_\_\_
- No - **Trauma:** Yes (Include type & date) \_\_\_\_\_
- No - **Other:** \_\_\_\_\_

(Over)

**Pregnancy:** Are you pregnant: Yes / No Are you planning on becoming pregnant within the next 3 months: Yes / No  
 Are you lactating: Yes / No

**Family Medical History:** Please CIRCLE each of the following for blood relatives, giving their relation and age when diagnosed.

- No - **Retinal detachment:** Yes -
- No - **Blindness:** Yes -
- No - **Glaucoma:** Yes -
- No - **Cataract:** Yes -
- No - **Cancer:** Yes (Include type):
- No - **Diabetes:** Yes -
- No - **Other:** Yes -

**Medicine Allergies (CIRCLE all that apply) -** None / Penicillin / Sulfa / Other:

**Latex Allergy:** Yes / No **Iodine Allergy:** Yes / No

**How much alcohol do you drink? (CIRCLE) -** None / Social / \_\_\_\_ drinks per day

**How much do you currently smoke? (CIRCLE) -** None / \_\_\_\_ packs per day for \_\_\_\_ years

**Former smoker (CIRCLE):** Never smoked

When did you stop smoking: \_\_\_\_\_

How much did you used to smoke: \_\_\_\_ packs per day for \_\_\_\_ years

**Do you drive? (CIRCLE) –** Yes / No

**What kind of diet do you eat? (CIRCLE) Normal / Diabetic / Low salt / Other:**

**Do you take any vitamins? (CIRCLE) No / Yes:** Which ones \_\_\_\_\_

**Do you take any herbs or other supplements? (CIRCLE) No / Yes:** Which ones \_\_\_\_\_

**Medications:** Please give name, strength, and how often you take every medication.

**Eye Drops**

Name of Drop (or reason why you take it)	Strength of drop (%)	How many times a day do you take it?
1.		
2.		
3.		
4.		
5.		

**Medications**

Name of Medicine (or reason why you take it)	Strength of Medicine (mg)	How many times a day do you take it?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		