PATIENT MEDICAL HISTORY

Name ____ Date _________________

Last Vision Exam____________ Eyecare Physician ___________________________

Please list any problems with your eyes or vision? _______________________________

____

Last Medical Exam___________ Family Physician ___________________________

How is your general health? ____

____

Current Medications (prescription and over the counter)

____

Current Eyedrops (prescription and over the counter)

____

Medication Allergies ____

Hayfever or other allergies ____

List any injuries to your eyes ____

List any surgeries on your eyes ____

Any Family History of eye disease?

	Self	Family Member
_____ Cataracts (clouding of the lens)	☐	☐
_____ Glaucoma (high eye pressure)	☐	☐
_____ Macular Degeneration (central vision loss)	☐	☐
_____ Strabismus (turned eye)	☐	☐
_____ Amblyopia (lazy eye)	☐	☐
_____ Diabetic Eye Disease	☐	☐
_____ Retinal Detachment	☐	☐

Contact Lens History:

Brand of Contact Lenses? _________________________________

How often do you replace your lenses? _________________________________

Do you sleep in your lenses? _________________________________

What brand of contact lens solution do you use?

☐ Optifree ☐ Complete ☐ Renu ☐ Biotrue

☐ Clear Care ☐ Boston ☐ Other __________________

What, if any, rewetting drops do you use? ________________________________