PATIENT HISTORY

Please check all that apply:

Do you ever experience any of the following:

□ Blurred vision-distance □ Itching □ Headaches □ Dryness □ Pain
□ Blurred vision-near □ Tearing □ Flashing lights □ Light sensitive □ Glare
□ Fluctuating vision □ Burning □ Floating Spots □ Temporary loss of vision
□ Double Vision □ Redness □ Eye Strain □ Eye Injury
Other: _____

Have you ever been diagnosed with any of the following EYE CONDITIONS:

□ Glaucoma □ Cataract □ Macular Degeneration □ Retina condition □ Keratoconus
Other: _____

Have you ever had any EYE SURGERY for the following:

□ Eyeturn/Muscle □ Retina □ Cataract □ Glaucoma □ Cornea
□ Vision Correction – PRK, LASIK, RK, AK, ALK
Comments: _____

Contact Lens History:

□ None □ Soft Daily Wear □ Soft Overnight Wear □ Soft Toric □ Hard/RGP/PMMA
Number of years: _____ Contact Lens Last Used: _____
Difficulty with CL Wear: Yes No End of day discomfort with CL Wear: Yes No
Comments: _____

Eyeglass History:

□ None □ Reading □ Distance □ Progressive □ Bifocals Number of Years:_____

Medical Information:

Allergies: □ None List: _____
Medications: □ None List: _____

General Health Conditions:

□ Diabetes □ Migraine □ Cholesterol □ Shingles □ Thyroid
□ Lung Condition □ High Blood Pressure □ Cancer □ Arthritis □ Heart Disease
Other: _____

FAMILY HISTORY

□ Glaucoma □ Macular Degeneration □ Cataracts □ Cancer – eyes/lids
□ Heart Disease □ Thyroid Disease □ Diabetes □ High Blood Pressure
Other: _____