PATIENT HISTORY FORM

(PLEASE PRINT)

DATE: ____________________

NAME: ____

- Date of last eye exam: ______________ Doctor/Office: ______________________
- Date of last physical: ______________ Doctor/Office: ______________________
- Do you wear glasses? Y ☐ N ☐ What kind? ______________________
- Do you wear contacts? Y ☐ N ☐ Brand/strength? ______________________
- Are you pregnant? Y ☐ N ☐ If so, how far along? ________ Nursing? Y ☐ N ☐

List major injuries/surgeries: ____

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SOCIAL HISTORY

Do you use:	NO	YES		
Tobacco	☐	☐	How long/amount:	______________
Alcohol	☐	☐	How long/amount:	______________
Illicit drugs	☐	☐	How long/amount:	______________

FAMILY HISTORY

FAMILY HISTORY	NO	YES		
Blindness	☐	☐	Relation to you:	______________
Glaucoma	☐	☐	Relation to you:	______________
Macular Degeneration	☐	☐	Relation to you:	______________
Cataracts	☐	☐	Relation to you:	______________
Crossed eye/Lazy eye	☐	☐	Relation to you:	______________
Other eye problem	☐	☐	Relation to you:	______________
Diabetes	☐	☐	Relation to you:	______________
High blood pressure	☐	☐	Relation to you:	______________
Heart disease	☐	☐	Relation to you:	______________
Thyroid disease	☐	☐	Relation to you:	______________
Arthritis	☐	☐	Relation to you:	______________
Cancer	☐	☐	Relation to you:	______________
Other ______________	☐	☐	Relation to you:	______________
Other ______________	☐	☐	Relation to you:	______________