MEDICAL AND SOCIAL HISTORY

Name:		Nickname:
Today's Date:	Age:	Date of Birth:
Approx date of last eye exam:	Name of previous eye doctor or clinic:	
Occupation:	Number of hours on computer per day:	
Hobbies/Sports:		
Any medical conditions that we should be aware of?		
Females, are you pregnant and/or nursing? ☐ Yes ☐ No	Allergies (Including medications):	
What medications are you taking?		
Have you ever had any eye injuries or surgeries? Explain:		
Are you interested in LASIK refractive surgery and would like to see if you are a candidate? ☐ Yes ☐ No		

What is the reason for today's visit? What visual/ocular problems are you having?

☐ Routine Only, no problems

I am currently having problems with: (please check appropriate boxes below)

☐ Blurred vision at distance	☐ Blurred vision at near	☐ Dry Eyes	☐ Headaches (often or severe)
☐ Eyestrain	☐ Itchy Eyes	☐ Watery Eyes	☐ Floaters/Flashes of light

Do you or any of your blood relatives have or have had any of the following?

	Self/Family	Comments
Glaucoma	Y N	
Cataracts	Y N	
Macular Degeneration	Y N	
Diabetes	Y N	
Seasonal allergies	Y N	Does it affect your eyes?
Lazy Eye/Crossed Eye	Y N	
Blindness	Y N	
Other:		

Contact Lens Wearers Only

- What type of contacts do you wear?
- How old are your current contacts?
- How many hours a day do you wear contacts?
- Do you ever sleep in your lenses? How often?
- How often do you replace your lenses?
- What solutions do you use?