|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | Age: | Date: | | |
| **Have you had a history of:** | **Yes** | **No** |  | | | **Yes** | **No** |
| Double vision |  |  | Diabetes | | |  |  |
| Decreased or blurred vision spells |  |  | High blood pressure | | |  |  |
| Eye pain |  |  | Heart disease | | |  |  |
| Floaters in your vision |  |  | Lung disease | | |  |  |
| Flashing lights |  |  | Neurologic disease/stroke | | |  |  |
| Eye injury |  |  | Thyroid disease | | |  |  |
| Serious eye infection |  |  | Ear, nose, mouth, throat problems | | |  |  |
| Eyelid problems |  |  |  | | |  |  |
| Abnormal pupil |  |  | Eye Surgery (list) | | |  |  |
| Cornea disease |  |  |  | | |  |  |
| Glaucoma |  |  |  | | |  |  |
| Cataract |  |  | Other surgery (list) | | |  |  |
| Retinal disorder |  |  |  | | |  |  |
| Eye tumor |  |  |  | | |  |  |
| In or out turning of eye |  |  |  | | |  |  |
|  |  |  | **Is there a family history of:** | | |  |  |
|  |  |  | Cataracts | | |  |  |
| Allergies to eye drops (list) |  |  | Glaucoma | | |  |  |
|  |  |  | Diabetes | | |  |  |
|  |  |  | Macular Degeneration | | |  |  |
| Allergies to medications (list) |  |  | Blindness (any cause) | | |  |  |
|  |  |  | Lazy Eye | | |  |  |
|  |  |  | Other eye disorders | | |  |  |
|  |  |  | Cancer | | |  |  |
| Are you experiencing fever/weight loss? |  |  | HBP | | |  |  |
| What is (was, if retired) your occupation? | | | | | | **Yes** | **No** |
| Do you smoke now? | | | | | |  |  |
| Have you smoked for 1 year or more? | | | | | |  |  |
| Do you drink alcohol daily? | | | | | |  |  |
| Have you had a flu shot vaccination in the last year? | | | | | |  |  |
| Are you concerned that you occupation adversely affects your eyes? | | | | | |  |  |
| Are you HIV Positive? | | | | | |  |  |
| Do you drive? | | | | | |  |  |
| Do you have problems with night vision? | | | | | |  |  |
| **Comments** (Regarding YES Answers) | | | | | |  |  |
|  | | | | | |  |  |
|  | | | | | |  |  |
|  | | | | | |  |  |
|  | | | | | |  |  |

**History Review**: No Changes Additions as Noted

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_