Reason for Exam today [ ] Medical Problem (check issues below)
[ ] Routine, Preventative Exam (no medical issues - insurance may not pay for this!)

Your Last Exam today [ ] By Ophthalmologist (physician MD or DO)
[ ] by Optometrist (OD, non-physician)
Date or about when

Which "medical problems" of your eyes apply to you for today's visit...

[ ] Recent loss of vision	[ ] Blurry distance vision	[ ] Blurry near vision
[ ] Poor night vision	[ ] Poor side vision	[ ] Redness or eye or eyelids
[ ] Eye pain	[ ] Possible foreign object	[ ] Burning, itching, sandy sensation
[ ] Excessive tearing	[ ] Discharge or pus	[ ] Crusty or missing lashes
[ ] Double vision (side by side)	[ ] Double vision (on top of each other)	
[ ] Seeing flashing lights	[ ] Seeing cobwebs, dark spots or dark veils	
[ ] Headaches affecting eyes	[ ] Growths of eyelids	[ ] Styes or chalazion
[ ] Light sensitivity	[ ] Halos around lights	
[ ] Crossed eyes as child	[ ] Poor vision since child	[ ] A lazy or weak eye

[ ] Other (describe):

Which contact lens brand do you use? [ ] None [ ] I have the boxes [ ] Don't know Other:

Please describe any prior Eye Problems, Treatments or Surgeries...

Serious injury	[ ] No [ ] Yes (describe):
Cataract Surgery	[ ] No [ ] Yes (describe):
Glaucoma	[ ] No [ ] Yes (describe):
Macular Degen.	[ ] No [ ] Yes (describe):
Retinal detach.	[ ] No [ ] Yes (describe):
Lid surgery	[ ] No [ ] Yes (describe):
Diabetes in eye	[ ] No [ ] Yes (describe):
Other (describe)	

Social History

Smoking history [ ] Never [ ] Quit ___ years ago [ ] Smoker Year started _____ How many per day _____

Drink alcohol [ ] No **How often** [ ] Daily [ ] Weekends [ ] Once/week **How many drinks at one time:**

Family History of Eye and other Medical Problems - If "Yes" what relationship

Blindness	[ ] Yes	**Crossed Eyes**	[ ] Yes
Cataracts	[ ] Yes	**Diabetes**	[ ] Yes
Glaucoma	[ ] Yes	**Hypertension**	[ ] Yes
Retinal Detach.	[ ] Yes	**Thyroid Disease**	[ ] Yes

Other (describe)

ALL Current Medications, even if not for the eyes!

Medication Name	Strength (mg, puffs) and How Often

Medication Allergies

Allergies, Reaction Type	[ ] None	[ ] Pencillin	Other
	[ ] Sulfa Drugs	[ ] Novacaine	Other
	Other	Other	Other