GENERAL HISTORY

Name:____ Date _____/_____/_____

Thank you for choosing our office for your eye care. Please answer the following questions:

1. Do you wear glasses? ____yes ____no Do you wear contact lenses? ____yes ____no
3. Do you have problems reading? _____yes _____no
4. Are you currently experiencing any eye symptoms? Please circle all that apply:

   Blurred Vision   Decreased Vision   Discharge   Double Vision   Eyelid Crusting

   Eye Pain   Flashes of Light   Floaters   Halos   Light Sensitivity

5. Have you ever had an eye injury? Please describe:______________________________

   ____

6. Have you ever had eye surgery? Please list type, which eye and approximate dates:

   ____, R / L ______ / ______ / ______

   ____, R / L ______ / ______ / ______

7. Are you currently using any eye medications? Please list name and how often used:

   ____

8. Are you being treated for any medical conditions? Please circle all that apply:

   Arthritis   Diabetes   Heart Disease   High Blood Pressure

   Stroke   Other: ____

9. Do you have a family history of any of the above?______________________________
10. What medications other than above are you taking? Please list: ________________

    ____

11. Are you allergic to any medications? Please list: _____________________________

    ____

12. Do you have any family history of eye problems? Please circle and list family relationship:

    Cataract______ Glaucoma______ Macular Degeneration ______ Retinal Disease

13. Please circle any of the following that you would like more information about:

    Cataract Surgery   Contact Lenses   Diabetic Eye Disease   Glaucoma

    Radial Keratotomy   Other____

14. Do you smoke cigarettes? Yes _____ No _____
15. Do you consume alcohol? Yes _____ No _____