|  |  |  |
| --- | --- | --- |
|  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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_