Date of last eye exam: _________________ Previous Eye Doctor: ____

Current occupation: ___________________ Hours per day using a computer: _____________________________

Hobbies/Sports: ____

Are you interested in Laser Refractive Surgery? Y / N

Are you interested in Corneal Refractive Therapy or contact lenses? Y / N

Have you ever worn contacts? Y / N Reasons for stopping? ____

Do you currently wear contacts? Y / N How many hours per day? _________ How many days per week? _________

Do you currently wear glasses? Y / N ____Full time ____Distance only ____Near only ____Bifocal ____Computer

How old are your current prescriptions for contacts? _________ Glasses? _________ Do you wear sunglasses? Y / N

Please mark any of the following symptoms you experience:

___ Decreased distance vision	___ Headaches	___ Redness	___ Dry Eyes
___ Decreased near vision	___ Glare while driving	___ Itchy eyes	___ Irritation/Burning
___ Decreased night vision	___ Eyestrain	___ Watery eyes	___ Hay fever
___ Decreased side vision	___ Floaters	___ Double vision	___ Flashes of light
___ Light sensitivity	Other symptoms: ______________________		

Current medications, vitamins and/or herbal supplements: ____

____

Allergies to medications: ____

Eye History:	**Self**	**Blood relative and Whom?**	
Amblyopia (Lazy Eye)	Y / N	Y / N	______________
Macular degeneration	Y / N	Y / N	______________
Retinal detachment	Y / N	Y / N	______________
Strabismus	Y / N	Y / N	______________
Glaucoma	Y / N	Y / N	______________
Blindness	Y / N	Y / N	______________
Cataracts	Y / N	Y / N	______________
Color Blindness	Y / N	Y / N	______________

Have you had vision therapy? Y / N When?___________________ If yes, what for? ___________________________

Have you had an eye injury or surgery? Y / N If yes, for what? ____

Medical History:	**Self**	**Blood relative and Whom?**	
Psychiatric (example: depression)	Y / N	Y / N	_______________
Allergies/Immunologic (hayfever, lupus)	Y / N	Y / N	_______________
Cardiovascular (high blood pressure, cholesterol)	Y / N	Y / N	_______________
Respiratory (asthma, COPD)	Y / N	Y / N	_______________
Neurological (stroke, M.S., migraines)	Y / N	Y / N	_______________
Musculoskeletal (arthritis, fibromyalgia)	Y / N	Y / N	_______________
Integumentary (acne or skin disorders)	Y / N	Y / N	_______________
Endocrine (diabetes, thyroid)	Y / N	Y / N	_______________
Gastrointestinal (Crohn's, IBS, acid reflux)	Y / N	Y / N	_______________

How is you general health? (Please circle) **Good** **Fair** **Poor**

Other (for example: cancer, kidney, liver, HIV, TB): ____

Do you use tobacco? Y / N Have you in the past smoked? Y / N When? _______________________________

Do you use recreational drugs? Y / N

Do you use alcohol? Y / N For doctor only: Dr. Sig __________

Are you or could you be pregnant? Y / N How many weeks? ___ For office only: Tech ID _________