

EYE HISTORY

• Please circle any of the following symptoms you may have with night vision.

Blurred vision Halos Glare Ghosting

• How old is the prescription in your glasses? _____

• Do you wear contact lenses? Yes No • Do you sleep in your contact lenses? Yes No

What type of lenses? _____

• How long have you been wearing contacts? _____

• When did you discontinue contact lens wear? _____

• Have you been treated for Dry Eye? Yes No

• Have you ever had any surgery, injuries or laser treatments to the eye? Yes No

If yes, please list: _____

• Are you currently corrected for or interested in Monovision? Yes No Do not know

• Do you or have you ever been treated for the following: (Check all that apply)

- Collagen, vascular, autoimmune, or immunodeficiency disease (e.g., Arthritis, Lupus or HIV)
- Signs of keratoconus (a corneal disease) or have any other condition that causes thinning of your cornea
- Corneal erosions or abrasions
- Glaucoma
- Lazy eye or wandering eye
- Herpes eye infections
- Taking Accutane for acne or Cordarone for controlling normal heart rhythm
- Presently pregnant or nursing
- Double vision (seeing two of the same image side by side or up and down)

• Is there any immediate family history of any of the following?

- Cataracts Glaucoma Strabismus (lazy eye) Retinal disease Cornea transplant Blindness

MEDICAL HISTORY

Primary Care Physician: _____ Practice Name: _____

Do you have or have you ever been treated for the following: (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Keloids | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Brain or nerve disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Bypass Surgery |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Other Heart Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Digestive Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Other Lung Disorders | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> HIV/ AIDS | |
| <input type="checkbox"/> Nephritis | <input type="checkbox"/> Cancer or tumor, Type: _____ | |
| <input type="checkbox"/> Diabetes, If so, how long? _____ | Are you presently using insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

List all medications that you are ALLERGIC to: _____

List all medications and dosages, including eye drops, that you are CURRENTLY taking, including those over the counter. Also include ANY recent vaccinations.

List all surgeries you have had: _____

