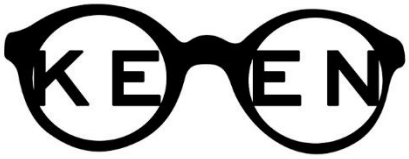

Patient History Intake Form

Name: _____ Date: _____

Last eye exam: _____ Occupation_____ Hobbies _____

Do you wear Glasses? Yes □ No □

Do you wear Contact Lenses? Yes □ No □

Are you interested in contact lenses today? Yes □ No □

Do you have any of the following Eye Conditions? Check all that apply.

□ Cataract □ Glaucoma □ Diabetic Retinopathy □ Dry Eye □ Eye infection/allergies

□ Floaters □ Flashes of light □ Iritis or Uveitis □ Retinal defects or degeneration

□ Other _____

Do you have any of the following Eye Concerns? Check all that apply.

□ Redness □ Burning □ Itching □ Tearing □ Discharge □ Other_____

Do you have any of the following vision concerns? Check all that apply.

□ Blurred Vision □ Eyestrain □ Eye Pain □ Severe Light Sensitivity □ Headache

□ Night time / Headlight Glare □ Double Vision □ Total loss of Vision □ Other _____

Review of Systems:

Diabetes? Y / N Type 1____ Type 2____ Last A1C? _____ Last Blood Sugar? _____

Please list any other **medical conditions** you have:

_____

Please list your **Primary Care Provider / family doctor**: _____

Please list all recent surgeries: _____

Please list all medications: _____

Please list any allergies: _____

Social and Medical History

Do you drink alcohol? Yes □ No □ How Much? _____ Do you smoke? Yes □ No □ How Much? _____

Please CIRCLE immediate family (Father/Mother/Brother/Sister) if they have any of these conditions:

□Hypertension F/M/B/S □Diabetes F/M/B/S □Hyperthyroid F/M/B/S

□Hypothyroid F/M/B/S □Cancer F/M/B/S □Cataracts F/M/B/S

□Glaucoma F/M/B/S □Macular Degeneration F/M/B/S