Date of Last 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? Y/N

Are you interested in contact lens exam? Y/N Have you ever worn contact lenses? Y/N Reason for stopping________________

Do you currently wear contact lenses? 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 Contact Lenses? ______ for Glasses?______ Do you wear sunglasses? Y/N

PLEASE MARK ANY OF THE FOLLOWING SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

__ 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: ____

Please list current medications, vitamin supplements and/or herbal supplements:____
____

List Allergies to medications:____

EYE HISTORY: please circle Yes/No

	Self	**Blood Relative**			**Self**	**Blood Relative**	
Amblyopia (Lazy Eye)	Y/N	Y/N	___________________	Glaucoma	Y/N	Y/N	_________________
Macular Degeneration	Y/N	Y/N	___________________	Blindness	Y/N	Y/N	_________________
Retinal Detachment	Y/N	Y/N	___________________	Cataracts	Y/N	Y/N	_________________
Strabismus (Eye Turn)	Y/N	Y/N	___________________	Color Blindness	Y/N	Y/N	_________________

Have you had vision therapy? Y/N If yes for what condition? ______________________________________When? __________________
Eye Injury Y/N If yes what____When?___________________
Eye Surgery Y/N If yes what____When?___________________

MEDICAL HISTORY: please circle Y/N and list condition **Self** **Blood Relative**

Psychiatric (example: depression, bipolar)……………………………………Y/N……………………………Y/N____________________

Allergies/Immunologic (hay fever, lupus)………………………………… ..Y/N……………………………Y/N____________________

Cardiovascular (high blood pressure, Cholesterol, heart disease)………………Y/N………………………………Y/N____________________

Respiratory (asthma, COPD, ect.)…………………………………………...Y/N…………………………….Y/N____________________

Neurological (stroke, M.S., migraines, ect)……………………………….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, ect.)……………………………Y/N……………………………Y/N____________________

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

Please list any medical surgeries you have had:____

How is your general health? (please circle one) GOOD FAIR POOR

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

Do you use recreation drugs? Y/N Do you use alcohol Y/N

FEMALE: Are you or could you be pregnant? Y/N IF YES: How many weeks**?**____