Samuel L. Weir, O.D.
Shannon Moore, O.D.
Lisa Butterfield, O.D.

MEDICAL HISTORY

Name_____ Date_____
Occupation_____ Employer_____

Reason for today's eye exam?_____ Last eye exam?_____

Do you use a computer? ☐ Yes ☐ No Hours/day_____ Distance from monitor_____

Do you drive? ☐ Yes ☐ No Do you have visual difficulty while driving? ☐ Yes ☐ No

Do you have difficulty with night vision? ☐ Yes ☐ No Difficulty with glare? ☐ Yes ☐ No

Are you interested in a free Laser Vision Correction evaluation? ☐ Yes ☐ No

GLASSES HISTORY

Do you currently wear glasses? ☐ Yes ☐ No Since_____
How old are the lenses in the glasses?_____

Type
☐ Single Vision Distance ☐ Trifocal ☐ Full Time
☐ Single Vision Reading ☐ Progressive ☐ Part Time
☐ Bifocal ☐ Safety Glasses ☐ Sports Glasses
☐ Back-up Glasses

Are you having trouble with your glasses? ☐ Yes ☐ No
If yes, why?_____

Do you wear sunglasses? ☐ Yes ☐ No With a current prescription? ☐ Yes ☐ No

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in being evaluated for contacts? ☐ Yes ☐ No

Have you ever tried wearing contact lenses? ☐ Yes ☐ No Since_____
Reason for stopping_____

Brand of contact lenses_____ Type ☐ Soft ☐ Hard/Gas Perm

Do you sleep with them in? ☐ Yes ☐ No How often do you remove them?_____
Wearing time? Hours/day_____ Days/week_____ Today_____
What solutions do you use?
Cleaner_____Disinfectant_____Enzyme_____

Please rate the following on a scale of 1-10 (1 = POOR, 10 = EXCELLENT)

	R	L		R	L		R	L
Comfort	_____	_____	**Distance Vision**	_____	_____	**Near Vision**	_____	_____

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, anti-glare tints or coatings)
☐ Occupational (mechanics, plumbers, pilots, etc.)
☐ Safety Glasses (gardening, woodworking, welding, etc.)
☐ Sports/Hobbies (please list your sports/hobbies below)

_____

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EYE HEALTH HISTORY
Do you currently have any of the following

☐ Blurred Distance Vision
☐ Blurred Near Vision
☐ Glare/Light Sensitivity
☐ Distorted Vision (Halos)
☐ Fluctuating Vision
☐ Amblyopia (Lazy Eye)
☐ Strabismus (Eye Turn)
☐ Double Vision
☐ Color Deficiency
☐ Itching
☐ Burning
☐ Excess Tearing/Watering
☐ Redness
☐ Mucous Discharge
☐ Infection of Eye or Lid
☐ Dryness
☐ Sandy or Gritty
☐ Foreign Body Sensation
☐ Eye Pain or Soreness
☐ Headaches
☐ Tired Eyes
☐ Droopy Eyelid
☐ Floaters or Spots
☐ Spontaneous Flashes of Light
☐ Loss of Vision
☐ Loss of Side Vision
☐ Injuries or Surgeries to Eyes (please list below)

_____

GENERAL HEALTH HISTORY
Do you currently have any of the following

Yes	No		Yes	No		Yes	No	
☐	☐	Respiratory (Asthma)	☐	☐	Allergic/Immunologic	☐	☐	Skin (Eczema/Rash)
☐	☐	Endocrine (Diabetes, Thyroid)	☐	☐	Muscles/Bones/Joints	☐	☐	Neurological
☐	☐	Blood/Lymph (Cholesterol)	☐	☐	Gastrointestinal	☐	☐	Fever
☐	☐	Kidney Disease	☐	☐	Ears/Nose/Throat	☐	☐	Weight Loss
☐	☐	Cardiovascular (High Blood Pressure, Heart)						

☐ Other (please list)_____

Past Illnesses/Injuries_____

Current Medications_____

Past Surgeries_____

Allergies (medicine/seasonal – please list) OR ☐ No Known Drug Allergies

FAMILY HISTORY

☐ Amblyopia (Lazy Eye)
☐ Strabismus (Eye Turn)
☐ Color Deficiency
☐ Cataract
☐ Glaucoma
☐ Other
(please list)_____
☐ Macular Degeneration
☐ Retinal Detachment
☐ Blindness
☐ Arthritis
☐ Cancer
☐ Lupus
☐ Heart Disease
☐ High Blood Pressure
☐ Kidney Disease
☐ Diabetes
☐ Thyroid
☐ Stroke

SOCIAL HISTORY

Do you take vitamins? ☐ Yes ☐ No
Do you engage in regular exercise? ☐ Yes ☐ No
Do you drink alcohol? ☐ No ☐ Occasional ☐ One per day ☐ 2-3/day ☐ 4+/day
Do you smoke? ☐ No ☐ Occasional ☐ ½ pack/day ☐ 1 pack/day ☐ 1+ pack/day