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

MEDICAL HISTORY

Name_____ **Date**_____

Occupation_____ **Employer**_____

Reason for today's 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 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 contacts? ☐Yes ☐No **If yes since when?**_____
If you discontinued contact lens use, reason for stopping?_____

Brand of contact lenses_____ **Type** ☐Soft ☐Hard/Gas Perm
Do you sleep in your contacts? ☐Yes ☐No **How often do you remove them?**_____
Wearing time? Hours/day_____ **Days/week**_____ **Today**_____
What solution do you use?_____

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
Are you currently suffering from or being treated for any of the following health issues

Y	N		Y	N		Y	N	
☐	☐	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 ☐ One per day ☐ 2-3/day ☐ 4+/day