

Shannon J. Moore, O.D.
Lisa Butterfield, O.D.
Barbara Masiello, 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

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

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

- | | | |
|--|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Respiratory (Asthma) | <input type="checkbox"/> <input type="checkbox"/> Allergic/Immunologic | <input type="checkbox"/> <input type="checkbox"/> Skin (Eczema/Rash) |
| <input type="checkbox"/> <input type="checkbox"/> Endocrine (Diabetes/Thyroid) | <input type="checkbox"/> <input type="checkbox"/> Muscles/Bones/Joints | <input type="checkbox"/> <input type="checkbox"/> Neurological |
| <input type="checkbox"/> <input type="checkbox"/> Blood/Lymph (Cholesterol) | <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> <input type="checkbox"/> Fever |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Ears/Nose/Throat | <input type="checkbox"/> <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> <input type="checkbox"/> Cardiovascular (High Blood Pressure/Heart) | | |
| <input type="checkbox"/> <input type="checkbox"/> Other (please list)_____ | | |

Past Illnesses/Injuries_____

Current Medications_____

Past Surgeries_____

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

FAMILY HISTORY

- | | | |
|--|---|--|
| <input type="checkbox"/> Amblyopia (Lazy Eye) | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Strabismus (Eye Turn) | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Color Deficiency | <input type="checkbox"/> Blindness | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Other (please list) | <input type="checkbox"/> Lupus | <input type="checkbox"/> Stroke |
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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