Name _____ **Date of Birth** _____ **Date** _____

MEDICAL/OCULAR HISTORY

Drug Allergies: _____

Surgical History: _____

_____

_____

Current Medications: _____

_____

_____

Smoking History: □ Current smoker □ Former smoker □ Never smoker

Medical Conditions that Apply to You:

□ Arthritis □ Asthma □ Cholesterol □ Headaches □ Heart Disease □ High Blood Pressure

□ HIV □ Lung Disease □ Rosacea □ Seasonal Allergies □ Seizures □ Shingles/Fever Blisters

□ Stroke □ Thyroid □ Cancer (please specify type) _____

□ Diabetes (if yes, most recent blood sugar count _____ and date taken _____)

□ Other: _____

Eye Conditions that Apply to You (past and present):

□ Cataract □ Color Blindness □ Corneal Disease □ Diabetes □ Double Vision □ Dry Eye

□ Glaucoma □ Lazy Eye □ Macular Degeneration □ Retinal Detachment or Tear

□ Other: _____

□ Glasses – how long: _____

Eye Surgery:

□ LASIK/PRK □ RK □ Cataract □ Glaucoma □ Retina □ Cornea Transplant

Surgery Details: _____

Eye/medical conditions of your immediate family:

□ Cataracts □ Glaucoma □ Diabetes □ Blindness □ Macular Degeneration □ Cornea

Any other type of ocular disease _____

Contact Lens History

Type of contact lenses you are wearing: □ Soft □ RGP □ Toric □ Multifocal □ Monovision

How long to you wear one pair of contact lens: □ 1 day □ 1-2 weeks □ 1-2 months □ other _____

Type of cleaning solutions used _____

Any allergies to contact lens _____

Any problems with current lenses _____