Primary Eyecare Professionals

Personal Eye Information

Do you wear glasses? Y N

If yes, do you have a Bifocal or Multifocal? Y N

Do you wear contact lenses? Y N

If yes, do you wear Soft or Rigid Lenses? ______________________

Have you had any eye operations? Y N

If yes, what type? ____

Date of procedure? _______________________________________

Have you ever had any eye injuries? Y N

If yes, what time?

Date of Injury? ____________________ *Eye(s) Affected? RT LT BOTH*

Have you been diagnosed with Glaucoma? Y N

Do you have Cataracts? Y N

Do you have Macular Degeneration? Y N

Do you have dry eyes? Y N

Do you have blurred vision? Y N

Do you suffer from night blindness? Y N

Any other eye problems you would like for us to know? ____

Family History

Blood Pressure?	Y	N	Relation: ____________________
Macular Degeneration?	Y	N	Relation: ____________________
Diabetes?	Y	N	Relation: ____________________
Retinal Detachment?	Y	N	Relation: ____________________
Glaucoma?	Y	N	Relation: ____________________
Cataracts?	Y	N	Relation: ____________________

Other genetic eye conditions that we should be aware of? ____

Medical Information

Do you have any problems with any of these symptoms? (Circle all that apply)

Gastrointestinal	Y	N	Diabetes	Y	N	Type: ________
Nervous	Y	N	Genitourinary	Y	N	
Mental	Y	N	Musculoskeletal	Y	N	
Ears/Nose/Throat	Y	N	Skin	Y	N	
Cardiovascular	Y	N	Endocrine(glands)	Y	N	
Respiratory	Y	N	Blood/Lymph	Y	N	
Allergic/Immunologic	Y	N	Headaches	Y	N	Frequency: __________

Allergies to Medications? ____

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