Medical History

Have you ever had an eye injury or surgery? ☐ Y ☐ N
If yes, explain: ____

Have you had a concussion? ☐ Y ☐ N
If yes, explain: ____

Do any of the following conditions apply to you?

☐ Distance Blur ☐ Near Blur ☐ Wear Glasses ☐ Wear Contacts ☐ Experience Eye Strain
☐ Itchy Eyes ☐ Itchy/Red Eyes ☐ Watery Eyes ☐ Swelling ☐ Mucous discharge
☐ Eye Fatigue ☐ Eye Crossing ☐ Eye Drifting ☐ Double Vision ☐ Dizziness
☐ Poor Balance ☐ Tends to reread ☐ Poor eye-hand coordination ☐ Skips/Repeats words when reading
☐ Poor reading comprehension ☐ Poor judgement of distance ☐ Tends to work too close
☐ Loses place while reading ☐ Light sensitive ☐ Frequent Headaches*

*If headaches, please mark all that apply:

☐ Stess induced ☐ Worse during work/school ☐ Worse during near centered tasks (reading)
☐ Worse during or following visual demanding activity ☐ Worse with 3D movies

Do you smoke: ☐ Yes ☐ No If yes, how much: ________________
Do you drink alcoholic beverages? ☐ Yes ☐ No How often: ___________________________
Do you use any other substances (including medical marijuana)? ☐ Yes ☐ No What: _______________________

Do you or a family member have any of the following conditions? Please label (**S**= Self **F**=Family Member)

___ High Blood Pressure ___ High Cholesterol ___ Diabetes ___ Heart Problems
___ Macular Degeneration ___ Diabetic Retinopathy ___ Glaucoma ___ Cataracts

Do you have a problem with any of the following bodily systems? If yes, please mark the box.

☐ Allergic/Immunologic ☐ Endocrine (glands) ☐ Mental ☐ Genitourinary
☐ Ear/Nose/Throat ☐ Bood/Lymph ☐ Gastrointestinal ☐ Nervous System
☐ Musculoskeletal ☐ Headaches ☐ Cardiovascular ☐ Respiratory

MEDICATION INFORMATION:

Please list current medications, including over-the-counter medicines, vitamins and supplements.

1. __________________________________ 2. ____
3. __________________________________ 4. ____

Are you allergic to any medicines? ☐ Y ☐ N If yes, please list: ____

I certify that the above information is correct and complete:

Signature ____________________________ Date:______________ Patient Name: ___________________________

Updated:

Signature _______________________________ Date:______________ Witness: __________________

Signature _______________________________ Date:______________ Witness: __________________