

MEDICAL HISTORY

Date: _____ Name: _____ Chart Number: _____

EYE HISTORY

Please circle **YES** or **NO** to the following questions.

Y= Yes

N=No

Y N 1) Have you had any eye surgery? If yes, please mark surgery below.

				Right	Left
<input type="checkbox"/>	Glaucoma Surgery	Year _____		_____	_____
<input type="checkbox"/>	Cataract Surgery	Year _____		_____	_____
<input type="checkbox"/>	Retina Surgery	Year _____		_____	_____
<input type="checkbox"/>	Laser Surgery	Year _____		_____	_____
<input type="checkbox"/>	Eyelid Surgery	Year _____		_____	_____
<input type="checkbox"/>	Corneal Transplant	Year _____		_____	_____
<input type="checkbox"/>	Lasik/PRK/RK/CK	Year _____		_____	_____
<input type="checkbox"/>	Eye Muscle Surgery	Year _____		_____	_____
<input type="checkbox"/>	Other Eye Surgery _____				

Y N 2) Have you ever worn glasses?
If yes, how old are the glasses? _____

Y N 3) Have you ever worn contact lenses?
If yes, were they:
Soft? _____
Gas Permeable/Hard? _____

Please mark **YES** or **NO** if you are experiencing any of the following eye problems:

Y <input type="checkbox"/>	N <input type="checkbox"/>	Dry eye	Y <input type="checkbox"/>	N <input type="checkbox"/>	Eye pain
Y <input type="checkbox"/>	N <input type="checkbox"/>	Red eye	Y <input type="checkbox"/>	N <input type="checkbox"/>	Eye injury
Y <input type="checkbox"/>	N <input type="checkbox"/>	Blurry vision	Y <input type="checkbox"/>	N <input type="checkbox"/>	Tearing
Y <input type="checkbox"/>	N <input type="checkbox"/>	Headaches	Y <input type="checkbox"/>	N <input type="checkbox"/>	Itching eyes
Y <input type="checkbox"/>	N <input type="checkbox"/>	Double vision	Y <input type="checkbox"/>	N <input type="checkbox"/>	Glare
Y <input type="checkbox"/>	N <input type="checkbox"/>	Floaters or Spots	Y <input type="checkbox"/>	N <input type="checkbox"/>	Light sensitivity
Y <input type="checkbox"/>	N <input type="checkbox"/>	Mucous or Drainage	Y <input type="checkbox"/>	N <input type="checkbox"/>	Stye or Lid Infection

Please circle **YES** or **NO** if you have been diagnosed with any of the following eye conditions:

Y	N	Glaucoma	Y	N	Cataract
Y	N	Macular Degeneration	Y	N	Corneal Disease
Y	N	Retinal Detachment	Y	N	Diabetic Eye Disease

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Please mark **YES** or **NO** if any blood relative have or had the following:

Y <input type="checkbox"/>	N <input type="checkbox"/>	Glaucoma	Y <input type="checkbox"/>	N <input type="checkbox"/>	Cataract
Y <input type="checkbox"/>	N <input type="checkbox"/>	Macular Degeneration	Y <input type="checkbox"/>	N <input type="checkbox"/>	Retinal Detachment
Y <input type="checkbox"/>	N <input type="checkbox"/>	Diabetes			

