



HISTORY FORM UPDATE

Clearly, our focus is on you!

Name _____ Age _____ Date _____

What is your reason for seeking care at this time? _____

Approximately how long ago was your last eye exam? _____

By what doctor or office? _____

Do you now wear glasses or contact lenses? Glasses Contact Lenses No Correction

If contacts are worn:

What type? RGP Soft Average wearing time per day (hrs) _____

Do you wear them over night? _____

Name of solutions used to care for them? _____

Have you ever had any eye disease, eye injury, or eye surgery? Yes No

If yes, please explain: _____

Circle any of the following eye symptoms or problems that you have experienced:

- flashes of light floaters double vision turned eye itching
burning dryness redness lazy eye cataracts
glaucoma eye strain light sensitivity blurred vision w/correction

Circle any of the following medical conditions that you have?

- Allergies High blood pressure Heart disease Lung problems
Diabetes Frequent Headaches Thyroid problems No health problems

Other _____

Personal Physician(s): _____

Please list any medications you are currently taking: _____

List any allergies to medications: _____

Does anyone in your family have any eye disease or health problems (i.e. glaucoma, macular

degeneration, eye turns, diabetes, high blood pressure, etc.)? Yes No

If yes, please list who & what: _____

I would like more information about: contact lenses eye disease prevention
refractive laser surgery glaucoma cataracts

other _____

Exams are to be paid for at the time of service. Materials are requested to be paid in full when ordered, and require a minimum of 50% deposit at the time of order, the balance to be paid when dispensed. No materials are dispensed until paid in full.