Today's Date:_____

Eye History

Patient's Name: _____

Reason for visit: _____

_____

Major Illnesses: _____ _____

_____ _____

Do you wear glasses? : Yes _____ No _____

If you wear glasses, are they for: Reading _____ Distance _____ Both _____

Do you wear contact lenses? : Yes _____ No _____ If yes, what type: _____

List any eye surgeries and when they were done:

_____

_____

_____

List and other surgeries and when they were done:

_____

_____

_____

Medications you are presently taking:

_____

_____

_____

_____

_____

Drug Allergies

_____

_____

_____

_____

_____

Any medications recently stopped or started: _____