

Health History

Purpose of Today's Visit: _____

Do you currently wear glasses? Yes No

Contact Lenses? Yes No

Have you ever worn contacts? _____ Are you interested in contacts:? _____

Are you interested in colored contacts? _____

Date of your last eye exam: _____ Where? _____

Do you have any of the following?

Eye Problems	
--------------	--

Health Problems	
-----------------	--

Yes	No	
_____	_____	Glaucoma
_____	_____	Cataracts
_____	_____	Eye Disease
_____	_____	Lazy Eye
_____	_____	Color Vision Problems
_____	_____	Double Vision
_____	_____	Eye Injury: _____
_____	_____	Eye Surgery: _____
_____	_____	Other: _____
_____	_____	_____
_____	_____	_____

Yes	No	
_____	_____	High Blood Pressure
_____	_____	Diabetes
_____	_____	Heart Problems
_____	_____	Arthritis
_____	_____	Thyroid Disease
_____	_____	Lung Disease
_____	_____	Skin Disease
_____	_____	Tobacco or Alcohol Use
_____	_____	Migraine/ Frequent Headaches
_____	_____	Allergies: _____
_____	_____	Drug Allergies: _____
_____	_____	Pregnant or Nursing

Do any of these problems run in your family (if so, which?) _____

Please list all medications you take regularly: _____

Who is your medical doctor? _____

For Children: Normal growth and development? _____ Premature Birth? _____

School Performance? _____ Behavioral Changes? _____

For Office Use Only - DO NOT FILL

Ear, Nose & Throat
 Gastrointestinal
 Psychological
 Genitourinary
 Dermatologic
 Headache/Neuro

• F
 • L
 • O
 • P
 • D
 • R

Cardiovascular
 Asthma/Breathing
 Musculo/Skeletal
 Hematologic
 Steroid Use
 Developmental
 Mental

