VISUAL HISTORY

Date of Last Eye Exam: ______________________________________ Where? ____________________________

Do you wear glasses? ________ If yes, how old is your present pair of lenses? ____________________________

Do you wear contact lenses? ____ If yes, how old is your present pair of contact lenses? ____________________

Type of contact lenses: __ Rigid __ Soft __Extended Wear __Disposable __ Other

Do you drive? _____ If yes, do you have any visual difficulty when driving? ________________________________

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, Retinal disease, cataracts, eye infections or injury: ____

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EYES

	NO	YES		NO	YES
Loss of Vision	__	__	Burning	__	__
Blurred Vision	__	__	Foreign Body Sensation	__	__
Distorted Vision/Halos	__	__	Excess Tearing/Watering	__	__
Loss of Side Vision	__	__	Glare/Light Sensitivity	__	__
Double Vision	__	__	Eye Pain or Soreness	__	__
Dryness	__	__	Chronic Infection of Eye or Lid	__	__
Mucous Discharge	__	__	Sties or Chalazion	__	__
Redness	__	__	Flashes/Floaters in Vision	__	__
Sandy or Gritty Feeling	__	__	Tired Eyes	__	__
Itching	__	__			

Please list all other family members:

Name	Age	Glasses/CL	Last exam	Name of Doctor
___________________	___	__________	_____________	______________
___________________	___	__________	_____________	______________
___________________	___	__________	_____________	______________
___________________	___	__________	_____________	______________

Family History: Please note any family history (parents, grandparents, siblings, children; living or deceased) for the Following conditions.

DISEASE/CONDITION	**NO**	**YES**	**RELATIONSHIP TO YOU**
Blindness	__	__	__________________________________
Cataract	__	__	__________________________________
Crossed Eyes	__	__	__________________________________
Glaucoma	__	__	__________________________________
Macular Degeneration	__	__	__________________________________
Retinal Detachment/Disease	__	__	__________________________________
Arthritis	__	__	__________________________________
Cancer	__	__	__________________________________
Diabetes	__	__	__________________________________
Heart Disease	__	__	__________________________________
High Blood Pressure	__	__	__________________________________
Kidney Disease	__	__	__________________________________
Lupus	__	__	__________________________________
Thyroid Disease	__	__	__________________________________
Other_____________________	__	__	__________________________________

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Doctor's Signature Date