Southglenn Eyecare
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OCULAR HISTORY

Are you currently experiencing any of the following problems with your eyes? (Check any that apply.)

- ❑ Blurred Vision
- ❑ Loss of Vision
- ❑ Double Vision
- ❑ Distorted Vision
- ❑ Tired Eyes
- ❑ Foreign Body Sensation
- ❑ Flashes/Floaters
- ❑ Halos/Glare/Light Sensitivity
- ❑ Excessive Tearing
- ❑ Dryness/Sandy or Gritty Feeling
- ❑ Eye Pain or Soreness
- ❑ Burning
- ❑ Mucous Discharge
- ❑ Itching

Please explain any checked box:

____

____

Have you ever been treated for or diagnosed with any of the following? (Check any that apply.)

- ❑ Cataracts
- ❑ Glaucoma
- ❑ Retinal Detachment
- ❑ Macular Degeneration
- ❑ Dry Eye
- ❑ Eye Injury
- ❑ Lazy Eye/Amblyopia
- ❑ Other______________

Please explain any checked box:

____

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Approximate date of your last eye examination: ____________________

Are you having any visual difficulties? _______ If yes, please explain:

____

Do you wear glasses? ❑ Yes ❑ No If yes, how old is your present pair? ______________________________________

Type of glasses: ❑ Progressive ❑ Trifocal ❑ Bifocal ❑ Single Vision ❑ OTC readers

Do you wear contact lenses? ❑ Yes ❑ No If yes, how old is your present pair? _________________________________

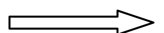
Type of contact lenses: ❑ Rigid ❑ Soft ❑ Toric ❑ Multifocal ❑ Hybrid

How often do you replace them? ______________ Brand/Power ____

Have you had refractive (LASIK, PRK, RK) surgery? ❑ Yes ❑ No

If yes, Date and Type____

Are you interested in finding out if you are a candidate for LASER refractive surgery? ❑ Yes ❑ N



FAMILY HISTORY Please note any family history (parents, grandparents, siblings, children)

	Relationship to you.		Relationship to you.
Glaucoma	___________________	Retinal Detachment	___________________
Cataract	___________________	Diabetes	___________________
Macular Degeneration	___________________	High Blood Pressure	___________________

Other____

MEDICAL HISTORY

List any medications you are currently taking and the condition treated: (include birth control, aspirin, OTC medications):

____

____

____

List any MEDICATION ALLERGIES you are aware of:

____

Please list any systemic surgeries:

____

____

Personal history Please check any that apply:

	Yes	No	NA		Yes	No	NA
Allergies	❑	❑	❑	**Integumentary (Skin)** (Rashes, Excessive dryness)	❑	❑	❑
Cardiovascular (High Blood Pressure, High Cholesterol)	❑	❑	❑	**Musculoskeletal** (Arthritis, Muscle/joint pain)	❑	❑	❑
Constitutional (Fever, Weight Loss)	❑	❑	❑	**Neurological** (Dizziness, Headaches, Migraines)	❑	❑	❑
Ears, Nose, Mouth, Throat (Sinus problems, Dry throat/mouth)	❑	❑	❑	**Psychiatric** (Anxiety, Depression)	❑	❑	❑
Endocrine (Diabetes, Thyroid Disease)	❑	❑	❑	**Respiratory** (Asthma, Chronic Bronchitis)	❑	❑	❑
Gastrointestinal (Heartburn, Ulcers)	❑	❑	❑	**Do you smoke?**	❑	❑	❑
Genitourinary (Urinary Problems, Kidney/Bladder problems)	❑	❑	❑	**Do you drink alcohol?**	❑	❑	❑
				Do you take recreational drugs?	❑	❑	❑
Hematologic/Lymphatic (Hepatitis, Blood Disorder)	❑	❑	❑	**Are you pregnant? Nursing?**	❑	❑	❑