

Patient History - Eyes

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Please print clearly.

PATIENT INFORMATION

Name		Birth Date	
Address		Zipcode	
Home#		Cell#	
Work#		Ext	
Occupation		Social Security#	
Employer		Referred By	
Responsible Person If minor			
Allergies to Medicines			

Please review the following list of medical problems, select the appropriate answer and, if applicable, give an explanation. Example: if you select yes for "itchy," an explanation would be "summer allergies."

EYES

When was your last eye exam?	☐ 1 year ago	☐ 2 years ago	☐ More than 2 years	
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Problem	Yes	No	Explanation
Eye injury	☐	☐	
Eye disease	☐	☐	
Surgeries	☐	☐	
Vision loss	☐	☐	
Blurred vision	☐	☐	
Distorted vision-halo	☐	☐	
Side vision loss	☐	☐	
Double vision	☐	☐	
Dryness in eye	☐	☐	
Mucous discharge	☐	☐	
Redness	☐	☐	
Sandy-gritty feeling	☐	☐	
Itching	☐	☐	

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EYES CONTINUED

Problem	Yes	No	Explanation
Burning	☐	☐	
Foreign body sensations	☐	☐	
Excess tearing-watering	☐	☐	
Occasional tearing	☐	☐	
Glare/light sensitivity	☐	☐	
Eye pain-soreness	☐	☐	
Infection eye or lid	☐	☐	
Sties-chalazion	☐	☐	
Fluctuating visual acuities	☐	☐	
Tired eyes	☐	☐	
Difficulty driving	☐	☐	
Night vision problems	☐	☐	
Other-please explain	☐	☐	