HEALTH HISTORY

Please fill out this information to the best of your ability. Providing incorrect information can be dangerous to your health. Please inform our office when there are any changes in the medical information you provide below.

Do you currently wear glasses? ☐ All the time ☐ Occasionally ☐ No
Do you wear them for ☐ Reading ☐ Computer Work ☐ TV ☐ Driving

What type of contact lenses have you worn in the past? ☐ Conventional Hard ☐ Extended Wear ☐ Gas Permeable
☐ Daily Wear Soft ☐ Toric ☐ Disposable ☐ Other ☐ None
If you have worn contact lenses in the past, do you still wear them? ☐ Yes ☐ No
If yes, have you worn them in the past 24 hours? ☐ Yes ☐ No

Have you ever had the following eye conditions? (please circle No or Yes, leave blank if uncertain)

Sandy or Gritty………....	No Yes	Glaucoma……………..	No Yes	Double Vision………..	No Yes
Itching………………….	No Yes	Cataracts……………....	No Yes	Mucous Discharge…….	No Yes
Dryness…………………	No Yes	Loss of Side Vision……	No Yes	Redness………………	No Yes
Burning…………………	No Yes	Loss of Vision………...	No Yes	Lazy Eye/Crossed Eye..	No Yes
Foreign Body Sensation.	No Yes	Blurred Vision………..	No Yes	Refractive Surgery……	No Yes
Excess Tearing………..	No Yes	Fluctuating Vision…….	No Yes	Macular Degeneration…	No Yes
Glare/Light Sensitivity…	No Yes	Distorted Vision……….	No Yes	Retinal Disorder……….	No Yes
Pain or Soreness……….	No Yes	Tired Eyes……………..	No Yes	Other…………………..	No Yes
Infection……………….	No Yes	Drooping Eyelids……...	No Yes		

Please circle "No" or "Yes" to indicate if you have had any of the following. Also circle to indicate if a blood relative has had any of the following conditions.

	Yourself	Family Member		Yourself	Family Member
AIDS/HIV	No Yes	No Yes	Hepatitis (type____)	No Yes	No Yes
Arthritis	No Yes	No Yes	High Blood Pressure	No Yes	No Yes
Asthma	No Yes	No Yes	Kidney Disease	No Yes	No Yes
Bleeding	No Yes	No Yes	Lazy Eye	No Yes	No Yes
Blindness	No Yes	No Yes	Lupus	No Yes	No Yes
Cancer	No Yes	No Yes	Migraines	No Yes	No Yes
Cataracts	No Yes	No Yes	Pacemaker	No Yes	No Yes
Diabetes	No Yes	No Yes	Poor Color Vision	No Yes	No Yes
Emphysema	No Yes	No Yes	Retinal Disease	No Yes	No Yes
Epilepsy	No Yes	No Yes	Rheumatic Fever	No Yes	No Yes
Eye Surgery	No Yes	No Yes	Shingles	No Yes	No Yes
Glaucoma	No Yes	No Yes	Skin Conditions	No Yes	No Yes
Hay Fever	No Yes	No Yes	Stroke	No Yes	No Yes
Heart Condition	No Yes	No Yes	Thyroid Condition	No Yes	No Yes
Macular Degeneration	No Yes	No Yes	Turned Eye	No Yes	No Yes

Are you pregnant? ___________ Number of children ___________

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Use of Tobacco: ☐ Never ☐ Previously, but not in the past ________ year(s) ☐ Current packs/day _________

Previous Hospitalizations/Surgeries/Serious Illnesses **When?**

____ ____________________
____ ____________________
____ ____________________

Please list medications you are currently taking, including non-prescription and any eye drops:

____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

Please list any allergies you may have to medications or other substances:

____________________ ____________________ ____________________
____________________ ____________________ ____________________