Peters Family Eyecare

Please complete the following form as thoroughly as possible. The information in this confidential form is critical to the evaluation of your vision and eye health.

Name: ______________________________________

DOB: _____________ Today's Date: ____________

Family Physician: _____________________________

Date of last physical checkup: __________________

Current Medications (RX or Over the Counter)

____
____
____

Allergies to Medications? YES or NO

If so, what medications? _______________________
____

Have you had any surgeries? YES or NO

Do you use cigarettes/tobacco, alcohol, or other substances? YES or NO

Have you ever been diagnosed or treated for the following health problems?

Allergies	Yes	or	No
Arthritis	Yes	or	No
Blood/Lymph	Yes	or	No
Bronchitis	Yes	or	No
Cancer	Yes	or	No
Cholesterol	Yes	or	No
Diabetes	Yes	or	No
Digestive	Yes	or	No
Ears/Nose/Throat	Yes	or	No
Endocrine	Yes	or	No
Eczema/Rashes	Yes	or	No
Fatigue	Yes	or	No
Fevers	Yes	or	No
Genitourinary	Yes	or	No
High Blood Pressure	Yes	or	No
Integumentary (Skin)	Yes	or	No
Kidney	Yes	or	No
Muscle/Bone	Yes	or	No
Neurological	Yes	or	No
Psychological	Yes	or	No

Date of Last Eye Exam: ________________________
By Whom? __________________________________

Have you tried contact lenses? YES or NO

Do you currently wear contacts? YES or NO
What kind? _________________________________
Solutions used: ______________________________

Are you satisfied with the vision & comfort of your contact lenses? YES or NO

Are you interested in a "test drive" of the latest in contact lens technology? Yes or No

If your glasses have a lined bifocal, do the lines or tilting your head bother you? Yes or No

Have you ever experienced, been diagnosed/treated for any of the following? (Check all that apply)

___ Blurry Vision
___ Burning
___ Cataracts
___Corneal Abrasions
___ Crossed Eye
___ Double Vision
___ Eye Infection
___ Eye Injury
___ Flashes of Light
___ Floaters/Spots
___ Glaucoma
___ Grittiness
___ Headaches
___ Iritis/Uveitis
___ Itchiness
___ Lazy Eye
___ Macular Degeneration
___ Occasional Dryness
___ Retinal Detachment
___ Sunlight Sensitivity
___ Tearing
___ Trouble seeing at night
___ Uncomfortable glasses
___Other eye disorders: ________________________

Is there a family history of the following? (State whether Mother's or Father's side.)

Blindness: __________________________________
Cataracts: ___________________________________
Corneal Problems: ____________________________
Diabetes: ___________________________________
Glaucoma: __________________________________
Heart Disease: _______________________________
Lazy Eye: ___________________________________
Macular Degeneration: _________________________
Retinal Problems: _____________________________