## Review of Symptoms

**Name:** _____ **Date:** _____

**Do you have or have you ever had any of the following Symptoms**

| | | |
|---|---|---|
| **1.** Loss of Vision | YES _____ | NO ____ |
| 2. Blurred Vision | YES _____ | NO ____ |
| 3. Tired Eyes | YES _____ | NO ____ |
| 4. Redness | YES _____ | NO ____ |
| 5. Itching | YES _____ | NO ____ |
| 6. Burning | YES _____ | NO ____ |
| 7. Sandy or dry eye | YES _____ | NO ____ |
| 8. Excessive tears | YES _____ | NO ____ |
| 9. Spots, halos, light flashes | YES _____ | NO ____ |
| 10. Light sensitivity/glare | YES _____ | NO ____ |
| 11. Double Vision | YES _____ | NO ____ |

## Personal Health History

High Blood Pressure YES___ NO___ Diabetes YES___ NO___

Glaucoma (high eye pressure) YES___ NO___ Cataracts YES___NO___

Macular Degeneration YES___NO___ Cardiovascular YES___NO___

**Family history of eye disease YES____NO___, if yes please explain:**

_____

_____

Have you ever worn contacts? YES____ NO ____

Are you interested in contacts? YES____ NO ____

**Have you had?** Any eye injuries YES___NO Crossed eye(s) YES___NO____

Any eye surgeries YES__NO___ Lazy eye YES___NO____

Eye infections YES___NO___

## Current Medication History

Please list below ALL PRESCRIPTION and over the counter medications you are now taking and what they are for. Please include any diet or birth control medications.

_____ _____

_____ _____

_____ _____

_____ _____

**Do you have any drug or other allergies? YES__NO__ If yes please list:**

_____ _____

**Payment is due on the date service are rendered unless prior arrangements have been made.**