2730 Wilshire Blvd, Suite 545
Santa Monica, CA 90403
310-315-9122

VISION/ HEALTH HISTORY

NAME: **DATE:**

1) Do you wear glasses? **Yes No** 2) Are they for: **Distance Reading Both**

3) Do you wear contact lenses? **Soft Lens Hard Lens** 4) Interested in contacts? _____

New patients only:

Soft Lens Brand:_____ Base Curve:_____

Right Eye Power:_____ Left Eye Power:_____

Eye Injuries: _____When?_____ Which eye?_____

Eye Surgeries: _____ When?_____ Which eye?_____

Other Surgeries: _____

Please check any symptoms you are experiencing or conditions you have:

- □ Blur at far with or without glasses
- □ Blur at near with or without glasses
- □ Red eyes
- □ Glare/halos
- □ Double Vision
- □ Floaters: Gradual/stable OR Sudden Onset
- □ Dry Eyes, burning or gritty eyes
- □ Chronic headaches
- □ Missing spots in field of vision
- □ Diabetes Type 1 or Type 2
- □ High Cholesterol
- □ Itchy eyes
- □ Strain/tired eyes at the computer
- □ Mucus discharge
- □ Flashes of light
- □ Eye pain/irritation
- □ Excess tearing
- □ Glaucoma
- □ Macular degeneration
- □ High blood pressure
- □ Thyroid disorder

List any additional symptoms/health conditions not mentioned above:

_____

Current medications:_____

Allergies to medication:_____

Family history of:

☐ Glaucoma Who?: _____

☐ Macular degeneration Who?:_____

☐ Diabetes Type 1 or Type 2 Who?: _____

☐ Other eye conditions:_____

SMOKER: YES NO IF YES, how many years? _____ Former smoker? Y or N

Alcohol consumption: YES NO # Drinks/week: _____