simplyeyes®

OCULAR HISTORY

NAME		**DATE**
DO YOU WEAR GLASSES?	YES ☐ NO ☐	Always ☐ Occasionally ☐ Work ☐ Reading Only ☐ Driving Only ☐
DO YOU WEAR CONTACT LENSES?	YES ☐ NO ☐	TYPE: ☐ Soft ☐ Gas Permeable — Brand of Contact Lenses:
CONTACT LENS REPLACEMENT SCHEDULE:		Daily ☐ 2 Weeks ☐ Monthly ☐ Quarterly ☐ Yearly ☐
HAVE YOU HAD LASIK / PRK? IF YES, WHEN?	YES ☐ NO ☐	Are you interested in LASIK or other refractive surgery? YES ☐ NO ☐
HAVE YOU EVER HAD ANY EYE INJURIES?	YES ☐ NO ☐	Please describe and indicate which eye:
HAVE YOU EVER HAD ANY EYE SURGERIES? IF YES, WHEN?	YES ☐ NO ☐	Please describe and indicate which eye:
HAVE YOU EVER BEEN DIAGNOSED WITH:	Cataract? YES ☐ NO ☐	Glaucoma? YES ☐ NO ☐ — Macular Degeneration? YES ☐ NO ☐ — Diabetic Retinopathy? YES ☐ NO ☐
PLEASE INDICATE ANY OF THE CONDITIONS THAT APPLY TO YOU:	☐ Blurred Far Vision ☐ Blurred Near Vision ☐ Poor Night Vision ☐ Double Vision	☐ Dry Eyes ☐ Watery Eyes ☐ Itchy Eyes ☐ Red Eyes — ☐ Floaters or Spots ☐ See Flashes ☐ Loss of Vision ☐ Light Sensitive — ☐ Headaches ☐ Eye Strain ☐ Eye Turn ☐ Eye Pain or Discomfort

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY EVER BEEN DIAGNOSED WITH THE FOLLOWING? IF A GRANDPARENT, INDICATE (M) MATERNAL OR (P) PATERNAL AND (GM) GRANDMOTHER OR (GF) GRANDFATHER.		
Blindness	☐ Yes ☐ No	Who?
Cataract	☐ Yes ☐ No	Who?
Glaucoma	☐ Yes ☐ No	Who?
Macular Degeneration	☐ Yes ☐ No	Who?
Retinal Detachment	☐ Yes ☐ No	Who?
Strabismus (Eye Turn)	☐ Yes ☐ No	Who?
Hypertension	☐ Yes ☐ No	Who?
Diabetes	☐ Yes ☐ No	Who?
Cancer	☐ Yes ☐ No	Who? Type?
Heart Disease	☐ Yes ☐ No	Who?
Thyroid Disease	☐ Yes ☐ No	Who?
Other:	☐ Yes ☐ No	Who?