CASE HISTORY

a. DATE OF THE LAST EXAM _____ DILATED? _____

b. REASON FOR THIS EXAM: _____ NOT SEEING WELL _____ HEADACHE

_____ EYE STRAIN _____ OTHER _____

c. ARE YOU INTERESTED IN: _____ GLASSES _____ CONTACTS
HAVE YOU EVER WORN: _____ GLASSES _____ CONTACTS

d. LIST ANY HOBBIES THAT REQUIRE SPECIFIC VISUAL REQUIREMENTS:

_____

e. HOW OFTEN DO YOU USE A COMPUTER? _____

f. HAVE YOU EVER HAD DIFFICULTY
ADJUSTING TO PRESCRIPTION CHANGES? _____ **YES** _____ **NO**

MEDICAL HISTORY

a. HAVE YOU EVER HAD AN EYE INJURY, EYE INFECTION, EYE DISEASE OR EYE OPERATION?

_____ **NO**
_____ **YES** / EXPLAIN _____

b. DO YOU HAVE A FAMILY HISTORY OF:

(CIRCLE YES OR NO)		**(FAMILY HISTORY)**
YES	**NO**	DIABETES _____
YES	**NO**	HIGH BLOOD PRESSURE _____
YES	**NO**	CATARACTS _____
YES	**NO**	GLAUCOMA _____
YES	**NO**	MACULAR DEGENERATION _____
YES	**NO**	RETINAL DETACHMENT _____
YES	**NO**	ALLERGIES_____
YES	**NO**	MEDICATION ALLERGIES _____
YES	**NO**	OTHER _____

c. HOW IS YOUR PRESENT HEALTH? _____ GOOD _____ FAIR _____ POOR

d. ARE YOU TAKING ANY PRESCRIPTION DRUGS? _____ **YES** _____ **NO**

NAME OF DRUGS: _____

e. DO YOU USE: CIGARETTES / TOBACCO? _____ **YES** _____ **NO**

ALCOHOL? _____ **YES** _____ **NO**

CASE HISTORY

a. DATE OF THE LAST EXAM _____ DILATED? _____

b. REASON FOR THIS EXAM: _____ NOT SEEING WELL _____ HEADACHE

_____ EYE STRAIN _____ OTHER _____

c. ARE YOU INTERESTED IN: _____ GLASSES _____ CONTACTS
HAVE YOU EVER WORN: _____ GLASSES _____ CONTACTS

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MEDICAL HISTORY

a. HAVE YOU EVER HAD AN EYE INJURY, EYE INFECTION, EYE DISEASE OR EYE OPERATION?

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YES	**NO**	RETINAL DETACHMENT _____
YES	**NO**	ALLERGIES_____
YES	**NO**	MEDICATION ALLERGIES _____
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d. ARE YOU TAKING ANY PRESCRIPTION DRUGS? _____ **YES** _____ **NO**

NAME OF DRUGS: _____

e. DO YOU USE: CIGARETTES / TOBACCO? _____ **YES** _____ **NO**

ALCOHOL? _____ **YES** _____ **NO**