

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**

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