PLEASE PRINT

OPTOMETRICAL HISTORY

Name _____ Date of Birth _____ Phone _____

Occupation _____ Hobbies _____

Please check YES or NO after considering each question carefully as each item may have some bearing upon the health, comfort or vision of your eyes.

Have you or any member of your family ever had:

Blindness	NO_____	YES_____
Cataract	NO_____	YES_____
Glaucoma	NO_____	YES_____
Eye turned in/out	NO_____	YES_____
Eye infection	NO_____	YES_____
Eye surgery	NO_____	YES_____
Diabetes	NO_____	YES_____
Heart problems	NO_____	YES_____
High blood pressure	NO_____	YES_____
Eye medications	NO_____	YES_____

Do you have any trouble seeing (with glasses or contact lenses if required):

Far away	NO_____	YES_____
Arms length	NO_____	YES_____
Close up	NO_____	YES_____

Do you or have you ever experience:

Allergies or sinus problems	NO_____	YES_____
Eye pain	NO_____	YES_____
Temporary loss or blurred vision	NO_____	YES_____
Problem headaches	NO_____	YES_____
Discharge from eyes	NO_____	YES_____
Flashes of light	NO_____	YES_____
Eye injury	NO_____	YES_____
Partial loss or greyness of vision or visual field	NO_____	YES_____
Double vision	NO_____	YES_____
Rainbows around lights	NO_____	YES_____
Red eyes	NO_____	YES_____
Itchy eyes	NO_____	YES_____

Do you or have you ever:

Worn glasses	NO_____	YES_____
Worn contact lenses	NO_____	YES_____
Had an eye patch	NO_____	YES_____
Undergone eye/vision training	NO_____	YES_____

Last complete medical examination ..... Date: _____

Family Doctor: _____

Do You Take Any Medications: .....

Last complete eye examination ..... Date: _____

Eye Doctor _____

THANK YOU. This information will greatly aid in the consideration and assessment of your ocular health, comfort and vision.