look MINNETONKA
EYECARE+OPTICAL SHOPPE

EYE HEALTH HISTORY

Date of last eye exam_____ Eye Clinic/Doctor Name_____

Do you currently wear glasses? Yes No If yes, how old are your current glasses?_____

If yes, when do you wear them?

☐ Always ☐ Reading/Near Work ☐ Distance Tasks ☐ Work/Safety

Are you planning to get new glasses today? Yes No Only if Rx changes

Have you ever worn contacts? Yes No Do you currently wear contacts? Yes No

Type of contacts if worn: ☐ Soft ☐ Rigid ☐ Disposable ☐ Bifocal

Are your contacts comfortable? Yes No Would you like to be fit for contacts today? Yes No

Have you ever been diagnosed with any of the following eye diseases?:

☐ Glaucoma ☐ Cataracts ☐ Macular Degeneration ☐ Retinal Detachment

☐ Strabismus (crossed or lazy eye) ☐ Other_____

Have you ever had an eye injury or surgery? Yes No Please describe_____

Are you currently using prescription or over the counter eye drops? Yes No

If yes please list _____

Do you currently or have you ever experienced:

☐ Loss of vision	☐ Eye pain/soreness	☐ Night vision problems	☐ Dry eyes
☐ Loss of side vision	☐ Red eyes	☐ Glare/light sensitivity	☐ Tired eyes
☐ Blurred vision	☐ Flashes/floaters	☐ Chronic Styes	☐ Burning/stinging
☐ Double Vision	☐ Headaches	☐ Droopy lids	☐ Itchy eyes

MEDICAL AND FAMILY HISTORY

Systemic health conditions can have serious eye health consequences. The following information will assist us in taking better care of your eyes.

Date of last medical exam_____ Primary Clinic/Physician_____

Do you have any allergies to medications? Yes No Which?_____

Are you pregnant or nursing? Yes No

Do you use cigarettes/tobacco? Yes No

List any medications you are currently taking (include vitamins, supplements and birth control)

Do you have problems with any of the following? If yes, check box and describe below.

☐ Gastrointestinal	☐ Nervous system	☐ Mental health	☐ Ear/nose/throat
☐ Cardiovascular/heart	☐ Urinary tract	☐ Endocrine/glands	☐ Musculoskeletal
☐ Blood/lymph	☐ Respiratory	☐ Skin conditions	☐ Migraines
☐ High cholesterol	☐ Allergic/immunologic	☐ Thyroid imbalance/disease	
☐ High blood pressure	☐ Diabetes Type 1 or Type 2 Recent A1C (if known)_____		

Please describe or list other systemic health conditions_____

Please note any family history (grandparents, parents, siblings) for the following:

☐ Glaucoma_____	☐ Other eye disease_____
☐ Macular degeneration_____	☐ High blood pressure_____
☐ Retinal detachment_____	☐ Diabetes_____

Doctor's Signature **Date**