Patient History

LAKES FAMILY EYECARE

Name: _____ Date: _____

Do you wear glasses? □ Y □ N Do you wear contact lenses? □ Y □ N □ Soft □ Gas permeable/hard □ Disposable

Have you ever worn contact lenses? □ Y □ N Are you interested in wearing contact lenses? □ Y □ N

Are you planning to get new glasses? □ Y □ N □ Maybe, depending on the exam

When was your last eye exam? _____ Name of the eye doctor: _____

Check all that apply: □ Itchy Eyes □ Stinging/Burning □ Red eyes □ Eye strain/eye fatigue
□ Blurry Vision □ Flashes/Floaters

Please check any of the following conditions you have/had:
□ Glaucoma □ Retinal Detachment □ Macular Degeneration □ Cataracts □ Dry Eyes

Do you have any other eye conditions or problems? If so, describe _____

_____

Have you had a serious eye injury or any eye surgery, including cataract or LASIK? If yes, please describe _____

_____

Are you using any eye drops (prescription or over-the-counter)? Please List:_____

_____

Please describe any problems with your eyes for which you are seeking treatment today: _____

_____

Patient Medical Information

Do you currently, or have you had, any problems in the following areas? (√) all that apply:

□ Cardiovascular/Heart Disease	□ Cancer	□ Headache
□ Respiratory	□ Endocrine/Glands	□ Nervous Systems
□ Blood/Lymph	□ Thyroid	□ Psychiatric/Psychological
□ High Blood Pressure	□ Gastrointestinal	□ Muscle/Bones
□ High Cholesterol	□ Urinary Tract	□ Integument/Skin
□ Diabetes (diagnosed: _____)	□ Ears/Nose/Throat	□ Allergic/Immunologic

Please Explain: _____

Other health problems: _____

Are you currently taking medication? □ Y □ N Please List: _____

_____

_____

Are you allergic to any medication? □ Y □ N Please List: _____

_____

Family Eye & Medical History

Please check (√) any conditions that have occurred in your immediate family:

□ Glaucoma	Relation: _____	□ Cataracts	Relation: _____
□ Macular Degeneration	Relation: _____	□ Retinal Detachment	Relation: _____

Patient Signature _____ Date _____