VISUAL HISTORY:

Name: ____________________

CHIEF COMPLAINT: Describe the main reason for the visit today:

More Indepth Description of Symptoms:

Condition: Blurriness? Aching? Pain?

Which Eye, Eye Part, or Part of Head if Headache?

How Long or When Did It Start?

How Severe?

Timing: Consistent? Comes/Goes? Improving?

Does Anything Help?

Any Other Symptoms Related to This Complaint? (Hard to Drive or Read, etc?)

Any Other Eye Issues or Problems?

Do you have a history of any of the following?

	YES	NO		YES	NO
Cataracts	☐	☐	Macular Degeneration	☐	☐
Glaucoma	☐	☐	Retinal Detachment	☐	☐
Blindness	☐	☐	Eye Turn (Strabismus)	☐	☐
Keratoconus	☐	☐	Lazy Eye (Amblyopia)	☐	☐

Are you currently experiencing any of the following?

	YES	NO		YES	NO		YES	NO
Blurred Vision	☐	☐	Eyes itch	☐	☐	Eyes frequently red	☐	☐
Double Vision	☐	☐	Eyes burn	☐	☐	Eyes feel sandy/gritty	☐	☐
Flashing lights	☐	☐	Eyes tear	☐	☐	Eyes "hurt" or "tired"	☐	☐
Floaters	☐	☐	Frequent styes	☐	☐	Halos around lights	☐	☐
Eyes feel dry	☐	☐	Headaches	☐	☐	Bothered by light / sun light	☐	☐

Are you pregnant or nursing? ☐ Yes ☐ No

Do you have, or ever had, any CHRONIC problems in the following areas?

	YES	NO		YES	NO		YES	NO
Diabetes	☐	☐	Arthritis	☐	☐	High blood pressure	☐	☐
Multiple Sclerosis	☐	☐	Allergies/Hayfever	☐	☐	Stroke	☐	☐
Migraines	☐	☐	Asthma	☐	☐	Anemia	☐	☐
Thyroid problems	☐	☐	Emphysema	☐	☐	Cancer	☐	☐

FAMILY HISTORY

☐ Family history is unknown/adopted

Any history of the following in any family members (parents, grandparents, siblings, children)?

	YES	NO	RELATIONSHIP TO PATIENT
Poor Vision	☐	☐	
Blindness	☐	☐	
Eye turn (Strabismus)	☐	☐	
Lazy Eye (Amblyopia)	☐	☐	
Glaucoma	☐	☐	
Cataracts	☐	☐	
Macular Degeneration	☐	☐	
Retinal Detachment/Disease	☐	☐	

	YES	No	RELATIONSHIP TO PATIENT
Cancer	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Thyroid Disease	☐	☐	
Other Inherited Disease	☐	☐	
If yes, what disease?			

General Physician ______________________________

Current Height ___ft ___in Weight ______lbs

Use of cigarettes: (please circle) Never Smoked, Current Every Day Smoker, Current Some Day Smoker, Former Smoker,

Do you wear glasses? Yes/No Contact lenses? Yes/No

Are you interested in Contact Lenses? Yes/No Refractive Surgery? Yes/No

Have you had any eye surgeries? Yes/No Type ______________________ Date __________

Have you had any eye injuries? Yes/No Type______________________ Date __________

Allergy to any medications? Yes/No To what?______________________________

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Please have a current list of medication(s) or list here: ______________________________

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