Name_____

EYE HISTORY:

*Help us know how you use your eyes* –What is your occupation?_____

What are your hobbies?_____

Are you a student?_____

How many hours do you work on computer per day?_____

**Do you have any of the following?**

Cataracts Yes/ No Glaucoma Yes/ No Macular Degeneration Yes/ No

**Are you experiencing or have experienced any of the following since your last eye exam**

Blurred Vision Yes/ No Flashes Yes/ No Glare/Light Sensitivity Yes/ No

Loss of Side vision Yes/No Floaters Yes/ No Eye Infection Yes/ No

Double Vision Yes/ No Halos Yes/ No

**Do you have any of the following sensations in your EYES today? (or recently)**

Fatigue □ Soreness □ Pain □ Pressure □ Foreign Body Sensation □

Dry/Sandy feeling □ Redness □ Burning □ Itching □ Eyelids Crusty □

Watery eyes □ Mucus-Like Discharge □

Have you had EYE surgery? *(list surgeries and which eye)*

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Are you Red/Green color deficient? Yes / No

**List any EYE drops you are using** *(over the counter and Prescription)*

_____

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