STRATFORD EYE CARE OPTOMETRY

NAME: _____ **DATE:** _____

EYE HISTORY
Date of Last Eye Exam?
Currently Wear Glasses?
Currently Wear Contacts?
Reason for Today's Visit

Please check if you or a family member have been treated for any of the following?

	Self	*Family (Relation)*
Cataracts		
Crossed Eye		
Glaucoma		
LASIK or RK		
Lazy Eye		
Macular Degeneration		
Retinal Detachment		

Are you currently experiencing, or have you experienced, any of the following? Check all that apply.

☐	Blurry vision	*near or distance*
☐	Burning	
☐	Discharge	
☐	Double Vision	
☐	Dryness	
☐	Excess Tearing/watering	
☐	Eye Infection	
☐	Eye Pain or Soreness	
☐	Floaters or Spots	
☐	Halos	
☐	Headaches	
☐	Itching	
☐	Light Sensitivity	
☐	Light Flashes	
☐	Redness	
☐	Sandy or Gritty Feeling	

MEDICAL HISTORY

Please check if you or a family member have been treated for any of the following?

	Self	*Family (Relation)*
AIDS/HIV		
Allergies		
Arthritis		
Asthma		
Blood/Lymph Disorder		
Cancer		
Diabetes *(circle: Type 1 Type 2)*		
Ears, Nose, Throat Conditions		
Gastrointestinal Conditions		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Kidney Disease		
Lupus		
Neurological Conditions		
Psychiatric Disorder		
Seizures		
Skin Conditions		
Stroke		
Thyroid Dysfunction *(High or Low)*		

Current Medications (Prescription and over-the-counter and dosage)

Medication Drug Allergies

Height	**Weight**
Are you pregnant or nursing?	
Do you smoke?	
Have you ever smoked?	
Do you consume alcohol?	

I have reviewed and updated all changes in my health history as indicated above.

Signature: _____ DATE: _____

Signature: _____ DATE: _____

Signature: _____ DATE: _____