Kenton Family Eye Care, Inc. Eye & Health History

Patient Name _____ Today's Date _____

What is the primary reason for your visit today? ☐ Vision Decrease ☐ Eye Health Problem ☐ Other

If you are a new patient, what was the date of your last eye exam? _____ By? _____

Do you currently wear glasses? ☐ Y ☐ N If yes, how old are your glasses? _____

When do you wear your glasses? ☐ Full time ☐ Distance vision ☐ Near vision ☐ Safety

☐ Computer ☐ Other _____

Do you currently wear contact lenses? ☐ Y ☐ N If no, are you interested in wearing them? ☐ Y ☐ N

Do you take any medications? ☐ Y ☐ N Please provide a written list or write them below

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Do you have any medication allergies? ☐ Y ☐ N If yes, please list them below.

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Do you have any seasonal or environmental allergies? ☐ Y ☐ N If yes, please list them below.

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Please check any of the following ocular symptoms that **YOU** experience:

☐ Loss of Vision ☐ Headaches ☐ Migraines ☐ Double Vision ☐ Blurred vision

☐ Eyes Itching ☐ Eyes Watering ☐ Eyes Burning ☐ Redness ☐ Mucous Discharge

☐ Gritty Feeling ☐ Dryness ☐ Light Sensitivity ☐ Styes ☐ Floaters or spots

☐ Loss of side vision ☐ Loss of color vision ☐ Decreased vision at night

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Please check any of the following ocular conditions that may apply to **YOU**:

☐ Cataracts ☐ Glaucoma ☐ Dry Eyes ☐ Color Blindness ☐ Eye Surgery

☐ Retinal Detachment ☐ Macular Degeneration ☐ Lazy Eye/Eye Turn

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Please indicate if any of the following apply to **YOU**:

☐ Pregnant ☐ History of Drug Abuse ☐ Smoker _____ packs per day for _____ years

☐ Nursing Mother ☐ History of Alcohol Abuse ☐ Former Smoker for _____ yrs, I quit _____ yrs ago

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Please indicate if any of the following applies to your close **FAMILY** history:

☐ Diabetes ☐ Glaucoma ☐ Cataracts

☐ Retinal Detachment ☐ Macular Degeneration ☐ Hypertension