

## 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

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

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

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

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

- Cataracts  Retinal Detachment  Glaucoma  Color Blindness  
 Eye Surgery  Macular Degeneration  Dry Eyes  Lazy Eye/Eye Turn  
 Diabetes  Hypertension  High Cholesterol

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

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

- Diabetes  Glaucoma  Cataracts  
 Retinal Detachment  Macular Degeneration  Hypertension