Patient History & Symptom Form

Patient Last Name		Patient First Name	
Patient Date of Birth			

1. Do you wear glasses?	Yes	No	
2. Do you wear contacts?	Yes	No	
3. At what age did you start wearing glasses (or contacts)?			
4. Have you worn contacts in the past?	Yes	No	
5. Do you have difficulty seeing at a distance WITHOUT glasses/ contacts?	Yes	No	
6. Do you have difficulty seeing at a distance WITH glasses/ contacts?	Yes	No	
7. Do you have difficulty seeing close or reading WITHOUT glasses/ contacts?	Yes	No	
8. Do you have difficulty seeing close or reading WITH glasses/ contacts?	Yes	No	
9. What is your occupation?			
10. List your main hobbies:			
11. Do you spend time or work on a computer or tablet?	Yes	No	Hours per day:
12. Do you spend time reading/ sewing/ crocheting/ knitting?	Yes	No	Hours per day:
13. Are your eyes sensitive to light?	Yes	No	
14. Do your eyes ever feel dry?	Yes	No	
15. Are your eyes ever crusty?	Yes	No	
16. Are your eyes ever red?	Yes	No	
17. Are your eyes ever itchy?	Yes	No	
18. Are your eyes ever puffy/swollen?	Yes	No	
19. Do your eyes ever burn?	Yes	No	
20. Do your eyes water a lot?	Yes	No	
21. Do you have sagging eyelids?	Yes	No	
22. Circle any of the medical concerns listed which apply to you:	Diabetes High Blood Pressure Cataracts Glaucoma Allergies Sinus Problems Cancer		
23. Do you have other vision or medical concerns the doctor should be aware of? If yes, please describe:	Yes	No	
24. Have you had surgeries or procedures on your eyes? If YES, please provide dates and description of each surgery & procedure:	Yes	No	
25. Circle the items your family has a medical history with:	Diabetes High Blood Pressure Glaucoma Cataracts		
26. Do you have a family history of other medical concerns the doctor should be aware of? If yes, please describe:	Yes	No	
27. Primary medical doctor's name:			
28. Primary medical doctor's location *(clinic name, city, state)*:			