Patient Name: ___________________________________ Email: _____________________________

Vision History

What brings you in to Cottage Grove Eye Care today? ____

What is the approximate date of your most recent eye exam? ____

Are you having difficulties with your vision? **YES / NO** If yes, then what type? **Distance / Near / Other**

Do you have any Eye Concerns at this time? (Circle) **redness / burning / itching / tearing / discharge**

Do you have any Vision Concerns at this time? (Circle) **blurry / eyestrain / pain / headache / double vision / severe light sensitivity / Vision loss / poor night vision / bothersome glare**

Do you spend any time on the computer or any other digital device? **YES / NO** If yes, how long per day? ______________________

Do you wear contact lenses? **YES / NO** If yes, how old are your current contacts? ____

Type of contact lenses you wear (circle): **Gas Permeable / Soft Extended Wear / Daily Disposable / Overnight**

What solution do you use to clean your contact lenses with? ____

Have you had any of the following eye conditions? (Circle) **Glaucoma / floaters / flashes / dry eye / cataracts / eye infection / iritis / Diabetic retinopathy / macular degeneration / uveitis / retinal defects**

Eye Surgery: (please specify type and date) ___________________________

Are you Pregnant? **YES / NO** Do you drink? **YES / NO** Do you smoke or use tobacco? **YES / NO**

Personal Medical History

List any medications that you take (e.g., over the counter meds, oral contraceptives, aspirin, and home remedies, etc.) Include dose:

____

Do you have any allergies (food / medications)? **YES / NO** If yes, please list allergies. ____

Please note any personal medical history for the following conditions: IF YES, PLEASE EXPLAIN.

Constitutional (developmental disabilities, cancer, fatigue syndrome)..........NO / YES ____________________________
ENT (hearing loss, sinusitis, dry mouth, laryngitis)..........NO / YES ____________________________
Neuro (MS, epilepsy, cerebral palsy, tumor, stroke, migraine)..........NO / YES ____________________________
Psych (depression, anxiety, bipolar, attention disorder)..........NO / YES ____________________________
Cardio (heart disease, hypertension, vascular, cong. Heart failure, stroke)..........NO / YES ____________________________
Respiratory (smoker, asthma, bronchitis, emphysema, sleep apnea, chronic obstruction)..........NO / YES ____________________________
GI (crohn's, colitis, ulcer, acid reflux, celiac) ....NO / YES ____________________________
GU (kidney, prostate, STD, pregnant, nursing, herpes, chlamydia) ....NO / YES ____________________________
Musc. /skel. (arthritis, osteoarthritis, fibromyalgia, dystrophy, ankylosing, spondylitis, osteoporosis, gout)........NO / YES ____________________________
Integ. (eczema, rosacea, psoriasis, herpes)..........NO / YES ____________________________
Endo. (diabetes, thyroid, hormonal dysfunction)..........NO / YES ____________________________
Hem. /Lymph. (anemia, large-vol. blood loss, ulcer, hypercholesteremia)..........NO / YES ____________________________
Allergy/Lmm. (drug, environmental, rheumatoid arthritis, lupus, sjorgren's syndrome)..........NO / YES ____________________________

Family History

Please note any family medical history for the following conditions: IF YES, THEN WHO?

Cancer..........NO / YES ____
Diabetes..........NO / YES ____
Hypertension ....NO / YES ____
Hyperthyroidism..........NO / YES ____
Hypothyroidism..........NO / YES ____
Cataract..........NO / YES ____
Macular Degeneration..........NO / YES ____
Glaucoma..........NO / YES ____

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