HEALTH HISTORY

for Frontier Family Vision

Name ______________________________ Age ________

Reason for today's exam ______________________________

Date of last exam ______________________ Name of eye doctor ______________________

Do you or anyone in your immediate family have a history of the following?

Diabetes	Blindness	High blood pressure
Cataracts	Thyroid	Turned or lazy eye
Glaucoma	Heart condition	

Please check any of the following conditions that apply to you:

Frequent headaches	Drug allergies	Pregnant
Allergies	Sinus trouble	Have given birth in the last 6 mor

Please list all medications you are currently taking: ______________________________

Have you ever had any of the following conditions involving your eyes?

Eye surgery	Sensitivity to light	Eye infection or disease
Eye injury	Floaters or spots	Double vision
Medical treatment	Poor distance vision	Eye Strain
Severe pain	Poor near vision	Eyes burn, itch, or water

Do you currently wear glasses? Yes No

When do you wear your glasses?

All the time	Reading/near work
Work safety	Distance tasks only
Computer work	Other, please explain ______________________

Have you ever worn contacts? Yes No

Are you interested in wearing contact lenses? Yes No

If so, what style?

Soft	Extended Wear	Gas Permeable	Bifocal
Tinted	Astigmatic	Disposable	Unsure

Do you work at a computer or video display terminal? Yes No

Are you interested in LASIK? Yes No

What hobbies or sports do you participate in? ______________________________

X ______________________________ ______________

SIGNATURE OF PATIENT (Enter Full Name as Signature) DATE