Ocular History for:

_____

Please print patient's name

BABCOCK EYE CARE

What is the reason for your visit?

_____

_____

Date of last eye exam: _____

Are you currently wearing glasses? ▫ Yes ▫ No

If yes, how old is your current pair of glasses? _____

Are you currently wearing contact lenses? ▫ Yes ▫ No

If yes, what brand of contact lenses do you wear? _____

Do you or your family have history of:

Glaucoma	▫ Yes	▫ No	▫ Family
Macular Degeneration	▫ Yes	▫ No	▫ Family
Crossed Eye	▫ Yes	▫ No	▫ Family
Lazy Eye (Amblyopia)	▫ Yes	▫ No	▫ Family
LASIK	▫ Yes	▫ No	▫ Family
Retinal Detachment	▫ Yes	▫ No	▫ Family
Cataracts	▫ Yes	▫ No	▫ Family
Ocular Injury	▫ Yes	▫ No	▫ Family

Do you currently or have history of:

Check all that apply.

- ▫ Blurred vision:
  - ▫ near ▫ intermediate/computer ▫ distance
- ▫ Burning
- ▫ Foreign body feeling
- ▫ Sandy/gritty feeling
- ▫ Dry feeling
- ▫ Itching
- ▫ Watery eyes
- ▫ Pain or soreness
- ▫ Redness
- ▫ Infection
- ▫ Discharge
- ▫ Floaters or spots
- ▫ Flashes of light
- ▫ Halos
- ▫ Vision loss
- ▫ Double vision
- ▫ Distortion
- ▫ Reading/learning disability

Please list any other eye related problems:

_____

_____

Ocular History for:

_____

Please print patient's name

Medical History:

Date of last physical: _____

Primary physician: _____

Are you pregnant or nursing? ▫ Yes ▫ No

Height: _____ Weight: _____

Please list all systemic surgeries:

_____

_____

Are you currently being treated for, or do you or your family have history of:

Hypertension or Cardiovascular Disease ▫ Yes ▫ No ▫ Family

High Cholesterol ▫ Yes ▫ No ▫ Family

Diabetes ▫ Yes ▫ No ▫ Family

Macular Degeneration ▫ Yes ▫ No ▫ Family

Glaucoma ▫ Yes ▫ No ▫ Family

Tobacco use ▫ Yes ▫ No ▫ Family

List all Medications and/or supplements:

Please include dosage, frequency, and route (i.e. oral, injection, etc.)

_____

_____

_____

_____

List any allergies you have to drugs, medications, and/or materials:

_____

Social History:

- Do you currently smoke? ▫ Yes ▫ No
  If yes, how often?
  ▫ Occasionally ▫ ½ pack/day ▫ 1+ pack/day
  If no, are you a former smoker? ▫ Yes ▫ No
  If yes, what type of use? ▫ Light ▫ Heavy

- Do you drink alcohol? ▫ Yes ▫ No
  If yes, how often?
  ▫ Occasionally ▫ 1/day ▫ 2/day ▫ 3+/day

- Drug dependency/abuse? ▫ Yes ▫ No
  If yes, what type?_____
  If no, did you have former dependency?
  ▫ Yes, what type? _____
  ▫ No