

Medical History

Do you have any allergies to medication? No Yes If so, please list: _____

Current medications (Please include oral contraceptives and over the counter medications) _____

Do you have any environmental allergies, such as hayfever? No Yes If so, please list: _____

List all major injuries or surgeries you have had: _____

For women, are you pregnant? No Yes

Do you smoke? No Yes

Please note any family history (parents, grandparents, siblings or children) with the following conditions:

DISEASE/CONDITIONS	NO	YES	YOURSELF	RELATIONSHIP OF RELATIVE TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Retinal Detachment/Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Vision History

Please check which of the following apply:

I have never worn glasses. I wear glasses now. I used to wear glasses.

I am interested in refractive surgery (LASIK, PRK, Corneal Rings, etc.)

Do you have any of the following symptoms? If so, please check.

Blurred vision with current prescription at: Far distances Intermediate distances Near distances

Discomfort working on computer Headaches Dry eyes

Red irritated or painful eyes Eyes turn in or out Double Vision

Are you interested in contact lenses? No Yes Do you currently wear contact lenses? No Yes

If so, please check the type of contact lenses:

Hard or Gas Permeable

Soft Contact Lenses

Disposable (Daily or extended wear) Conventional (Daily or extended wear)

Are you wearing your lenses today? No Yes If not, when did you wear them last? _____

How often do you change your contact lenses? _____ Age of your newest contact lenses? _____

I have read and/or received a copy of Foothill Optometric Group's Notice of Privacy Practices.

Signature

Date