ISLAND EYE SPECIALISTS

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MICRONESIA'S REGIONAL EYE CENTER SINCE 1997

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EYE HISTORY

Name: _____ Date: _____

Thank you for choosing our clinic for your eye care. To better serve you, PLEASE answer the following questions.

1. Do you wear reading glasses? ☐YES ☐NO If so, how old is your prescription? _____

2. Do you wear distance glasses? ☐YES ☐NO If so, how old is your prescription? _____

3. Do you wear contact lenses? ☐YES ☐NO If so, how old is your prescription? _____

☐HARD ☐SOFT ☐EXTENDED WEAR ☐DAILY WEAR

4. Are you **currently** experiencing any of the following symptoms? Please circle ALL that apply.

☐Pressure Pain	☐Sandy Sensation	☐Throbbing	☐Eyelid Crusting	☐ Excessive Tearing
☐Redness	☐Floaters	☐ Mucous Discharge	☐ Light Sensitivity	☐Flashing Lights
☐Itchiness	☐Halos	☐Double Vision	☐Loss of Vision	☐Blurry Vision
☐ Dryness	☐Burning Sensation			

Other: _____

5. Have you ever had an eye INJURY? ☐YES ☐NO If so, please describe and when _____
_____
_____

6. Have you ever had eye LASER treatment? ☐YES ☐NO If so please list type, which eye, and when
_____
_____

7. Have you ever had eye SURGERY? ☐YES ☐NO If so please list type, which eye, and when.
_____
_____

8. Are you currently using any eye medications? Please list name and instructions: _____
_____
_____

9. Are you currently being treated for any medical conditions? Please circle ALL that apply:

☐Diabetes	☐ Heart Disease	☐Hypertension	☐High Cholesterol	☐Stroke	☐Arthritis
☐Lupus	☐Thyroid Disease	☐Anemia	☐Kidney Disease	☐Tuberculosis	☐Cancer
☐Asthma	**Other:** _____				

10. Do you have any medication/food/drug ALLERGIES? ☐YES ☐ NO If so, please list type and reactions:
_____
_____

11. Does any FAMILY member(s) have a history of ANY of the following? Please circle ALL that apply:

☐Diabetic Retinopathy	☐Glaucoma	☐Cataract	☐Retinal Detachment	☐ Blindness	☐Retinal Disease
☐Macular Degeneration	☐Lazy Eye	☐Lupus	☐ Arthritis	☐Sjogren's Syndrome	