

Patient Name: _____

Reason for visit: _____

Recent Symptoms:

- Crossed or wandering eye
- Excessive squinting
- Frequent tearing or discharge
- Frequent headaches

History of Eye Problems: None

- Glasses
- Patching
- Eye surgery
- Eye injury

Other eye problems: _____

Do you wear glasses? Y___ N___ When was the last time you got new glasses/lenses _____

Have you ever worn Contact Lenses? Y___ N___ If yes, what type/brand? _____

Are you interested in wearing Contact Lenses? Y___ N___

What sports do you play? _____

What kind of work do you do? _____

Are you interested in **LASER VISION CORRECTION**? Y___ N___

Other Medical Problems: None

- Asthma/seasonal allergies
- Genetic disorder
- ADHD
- Heart problems
- Delayed development

Allergies to medications: None

List all medications: None

Family History of eye problems: None

- Amblyopia ("lazy eye")
- Strabismus ("crossed eye")
- Complications from anesthesia
- Genetic disease (runs in family)
- Glaucoma

Patient/Guardian Signature _____ Date _____

Doctor _____ Date _____