

Macali Eye Clinic

Name _____

EYE HISTORY

Glaucoma	<input type="radio"/> Yes <input type="radio"/> No
Cataract	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No
Headaches	<input type="radio"/> Yes <input type="radio"/> No
Glare/Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No
Burning	<input type="radio"/> Yes <input type="radio"/> No

Dryness	<input type="radio"/> Yes <input type="radio"/> No
Excess Tearing/Watering	<input type="radio"/> Yes <input type="radio"/> No
Eye Pain or Soreness	<input type="radio"/> Yes <input type="radio"/> No
Foreign Body Sensation	<input type="radio"/> Yes <input type="radio"/> No
Infection of Eye or Lid	<input type="radio"/> Yes <input type="radio"/> No
Itching	<input type="radio"/> Yes <input type="radio"/> No
Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No
Drooping Eyelid	<input type="radio"/> Yes <input type="radio"/> No
Redness	<input type="radio"/> Yes <input type="radio"/> No
Sandy or Gritty Feeling	<input type="radio"/> Yes <input type="radio"/> No

Strabismus (Crossed Eyes)	<input type="radio"/> Yes <input type="radio"/> No
Blurred Vision Distance	<input type="radio"/> Yes <input type="radio"/> No
Blurred Vision Near	<input type="radio"/> Yes <input type="radio"/> No
Distorted Vision (halos)	<input type="radio"/> Yes <input type="radio"/> No
Double Vision	<input type="radio"/> Yes <input type="radio"/> No
Floaters or Spots	<input type="radio"/> Yes <input type="radio"/> No
Fluctuating Vision	<input type="radio"/> Yes <input type="radio"/> No
Loss of Vision	<input type="radio"/> Yes <input type="radio"/> No
Loss of Side Vision	<input type="radio"/> Yes <input type="radio"/> No

GENERAL HEALTH CONDITION

Thyroid	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Other Symptoms	<input type="radio"/> Yes <input type="radio"/> No
Ears, Nose, Throat	<input type="radio"/> Yes <input type="radio"/> No
High blood pressure	<input type="radio"/> Yes <input type="radio"/> No

Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No
Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No
Kidney	<input type="radio"/> Yes <input type="radio"/> No
Muscles, Bones, Joints	<input type="radio"/> Yes <input type="radio"/> No
Skin	<input type="radio"/> Yes <input type="radio"/> No
Neurological (Multiple Sclerosis)	<input type="radio"/> Yes <input type="radio"/> No

Anxiety or Depression	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Blood/Lymph	<input type="radio"/> Yes <input type="radio"/> No
Allergic	<input type="radio"/> Yes <input type="radio"/> No
Are you?	<input type="checkbox"/> Pregnant <input type="checkbox"/> Nursing

FAMILY HISTORY

Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No
Blindness	<input type="radio"/> Yes <input type="radio"/> No
Cataract(s)	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No

Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No
Strabismus (Eye Turn)	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Heart Disease	<input type="radio"/> Yes <input type="radio"/> No

High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Lupus	<input type="radio"/> Yes <input type="radio"/> No
Stroke	<input type="radio"/> Yes <input type="radio"/> No
Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Others	<input type="radio"/> Yes <input type="radio"/> No

GLASSES AND CONTACT LENS HISTORY

Do you use a computer? Yes No How many hours/day? _____ Distance from Computer? _____

Do you have glare problems? Yes No

Do you have problems with night vision? Yes No

Do you currently wear glasses? Yes No Since _____

Type of glasses FullTime PartTime Distance Close

Have you had trouble in the past with glasses? Yes No

Do you wear sunglasses? Yes No Are your sun glasses your current prescription? Yes No

If not a contact lens wearer, are you interested in trying contact lenses at this time? Yes No

Have you ever tried to wear contact lenses? Yes No Reason for stopping? _____

Do you currently wear contact lenses? Yes No Since _____

Type and brand of contact lenses _____ Today's wearing time? _____

How many hours/day? _____ How many days/week? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

Do you drink alcohol? If yes, how much/often : No Occasional 1 Per Day 2-3/day 4+/day

Do you smoke? If yes, how much/often : No Occasional 1/2 pack/day 1 pack/day 1+ pack

Method of Tobacco Intake : Smoking Chewing

Do you use Illegal Drugs : Yes No