

NCT OD: \_\_\_\_\_  
OS: \_\_\_\_\_

**Medical History - Existing Patient**

Optomap: YES \_\_\_\_\_ NO \_\_\_\_\_

Date: \_\_\_\_\_

Patient Number: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Please list any changes in address, phone number or other personal data: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Currently taking medication(s) - (prescription and over-the-counter) Yes No

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
- 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Drug Allergies Yes No

If YES, Please list the medications: \_\_\_\_\_

List all eye injuries: \_\_\_\_\_

List any eye surgeries you have had: \_\_\_\_\_

**EYES (Current or Existing Problems Associated With)**

Loss of Vision	Yes	No	Sandy or Gritty Feeling	Yes	No
Blurred Vision (Near)	Yes	No	Glaucoma	Yes	No
Blurred Vision (Distant)	Yes	No	Itching	Yes	No
Fluctuating Vision	Yes	No	Burning	Yes	No
Loss of Side Vision	Yes	No	Excess Tearing/Watering	Yes	No
Double Vision	Yes	No	Glare/Light Sensitivity	Yes	No
Dryness	Yes	No	Infection of Eye or Eyelid (blepharitis/stye)	Yes	No
Mucous Discharge	Yes	No	Tired Eyes	Yes	No
Redness	Yes	No	Crossed Eyes/Lazy Eye	Yes	No

**REVIEW OF SYSTEMS (Current or Existing Problems Associated With)**

Ears, Nose, Throat (Sinus, Ear Infection, Cough)	Yes	No	Endocrine (Diabetes, Hypothyroid)	Yes	No
Cardiovascular (Heart, Vessels, etc.)	Yes	No	Blood/Lymph (Cholesterol, Anemia)	Yes	No
Respiratory (Asthma, Emphysema, etc.)	Yes	No	Allergic/Immunological (Hay Fever)	Yes	No
Gastrointestinal (Stomach Ulcers, Intestinal Disease, etc.)	Yes	No	Muscles, Bones, Joint (Arthritis, etc.)	Yes	No
Skin (Acne, Warts, Skin Cancer, etc.)	Yes	No	Neurological (Multiple Sclerosis, etc.)	Yes	No
Psychiatric (Anxiety, Depression, Insomnia)	Yes	No			

**FAMILY HISTORY**

Blindness	Yes	No
Glaucoma	Yes	No
Diabetes	Yes	No
Cataracts	Yes	No
Macular Degeneration	Yes	No

Relationship to Patient
_____
_____
_____
_____

**PERSONAL HISTORY**

Current Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_  
Divorced \_\_\_\_\_ Widow \_\_\_\_\_

Have you ever worn contact lenses? \_\_\_\_\_ Do you currently wear contacts? \_\_\_\_\_

How long have you worn contacts? \_\_\_\_\_ Do you currently wear glasses? \_\_\_\_\_