Name_____ **Please circle any that apply.**

Eye History

Do you wear glasses? No Single vision lenses Bifocals Trifocals
Progressive lenses

Do you wear Contact Lenses? No Gas permeable lenses Soft lenses
Bifocal lenses Monovision lenses

Do you wear your lenses as: Daily wear Extended wear

Who fit these contact lenses?_____
Please provide brand and lens specifications if known_____
_____

Are you currently experiencing any eye symptoms? Eye pain Blurred vision
Burning Decreased vision
Itching Crusting or discharge
Floaters Double Vision
Flashes

Other_____

Have you ever had an eye injury?_____

Please describe_____

Have you ever had eye surgery? _____
_____

Please describe and give approximate dates: _____

Are you using any eye medications? Medication How used
1._____
2._____
3._____
4._____
5._____
6._____

Are you allergic to any medications? If so please list:_____
_____
_____

Family History: Relationship
Glaucoma_____
Macular degeneration_____
Diabetic retinopathy_____
Retinal detachment_____
Cataracts_____
Other_____