



PATIENT HISTORY

OCULAR INFORMATION

Past Ocular History:	<input type="checkbox"/> None	Rx stable for 12 months (<0.50D)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Retinal Tear/Detachment
	<input type="checkbox"/> Keratoconous	<input type="checkbox"/> Strabismus	<input type="checkbox"/> Trauma/Foreign Body/ Scar
	<input type="checkbox"/> Amblyopia/Lazy Eye	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Herpes Simplex/Zoster

Past Ocular Surgery:	<input type="checkbox"/> None	<input type="checkbox"/> Muscle	<input type="checkbox"/> Retinal Surgery
	<input type="checkbox"/> PRK	<input type="checkbox"/> RK/AK	<input type="checkbox"/> ALK/LASIK
	<input type="checkbox"/> Cataract	<input type="checkbox"/> Corneal Transplant	
Dates: _____			

Contact Lens History:	<input type="checkbox"/> None	<input type="checkbox"/> Soft Daily Wear	<input type="checkbox"/> Soft Overnight Wear
	<input type="checkbox"/> Soft Toric	<input type="checkbox"/> RGP	<input type="checkbox"/> Hard PMMA
	Difficulty with CL Wear	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Contact Lenses Last Worn: _____			

MEDICAL INFORMATION

Medical Allergies:	<input type="checkbox"/> None	List: _____								
Medications:	<input type="checkbox"/> None	List: _____								
General Health Problems:	<input type="checkbox"/> None	List: _____								
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Arthritis: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="width: 50%;">Asthma: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Pregnant/Breast Feeding: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>High Blood Pressure: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Healing Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Claustrophobia: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>			Arthritis: <input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma: <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant/Breast Feeding: <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure: <input type="checkbox"/> Yes <input type="checkbox"/> No	Healing Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	Claustrophobia: <input type="checkbox"/> Yes <input type="checkbox"/> No	HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Comments: _____

MOTIVATION

Sports Career Poor Glasses/Comfort Contact Lens Intolerance
 Cosmetic Appearance Self-Confidence Simply Fed Up Other _____

In order for Woolfson Eye Institute to perform a complete eye exam during the consultation, a WEI Assistant may instill a pupil dilator drop. For my own safety, I will arrange to have a driver for the day of the consultation. Patients scheduled for screenings or pre-testing will not be given the pupil dilator drop (i.e. patients with a referring optometrist). I understand and agree to the above mentioned.

Patient Name: _____ Date: _____

Patient Signature: _____ WEI Assistant: _____