CPN Optometry History Form

(Place label here)

Please check if you (the patient) have any of the following Eye conditions.

- ☐ Cataracts
- ☐ Dry eyes
- ☐ Blurry vision
- ☐ Floaters or spots
- ☐ Light sensitivity
- ☐ Lazy eye
- ☐ Excess tearing/watering
- ☐ Eye pain/soreness
- ☐ Distorted vision (Halos)
- ☐ Double vision
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Redness
- ☐ Burning
- ☐ Retinal detachment
- ☐ Night vision problems
- ☐ Loss of vision
- ☐ Eye discharge
- ☐ Itchy eyes
- ☐ Flashes of light

Please check if you (the patient) have any of the following Health conditions.

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Diabetes
- ☐ Thyroid
- ☐ Stroke
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Hearing loss
- ☐ Sinus problems
- ☐ Allergies
- ☐ Heart burn
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Anemia
- ☐ Leukemia
- ☐ HIV/AIDS
- ☐ Rashes
- ☐ Psoriasis
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Arthritis
- ☐ Depression
- ☐ Anxiety
- ☐ Asthma
- ☐ COPD
- ☐ Lupus
- ☐ Crohn’s disease
- ☐ Autism
- ☐ Pregnancy
- ☐ Bladder/Kidney
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Sleep apnea
- ☐ Other

When was your last eye exam? ____________________

How old are your current glasses? ____________________

List any prescription or over the counter medications or eye drops (That you DO NOT receive here at the CPN pharmacy).

____

____

List any medications you are allergic to

____

List any Major eye surgeries you've had

____

Family Ocular History (Check all that apply)

- ☐ Glaucoma if yes, who in your family has it? ____
- ☐ Macular degeneration if yes, who in your family has it? ________________________________

Family Medical History (Check all that apply)

- ☐ Diabetes
- ☐ High blood pressure

Social History

Do you drink alcohol?

- o Yes
- o No

Do you smoke?

- o Yes
- o No

Do you use chewing tobacco?

- o Yes
- o No