## 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?

☐ Yes

☐ No

Do you smoke?

☐ Yes

☐ No

Do you use chewing tobacco?

☐ Yes

☐ No