CPN Eye Care History Form

(Place label here)

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

- ☐ **Cataracts**
- ☐ **Dry eyes**
- ☐ **Blurry Vision**
- ☐ **Floaters or Spots**
- ☐ **Light Sensitivity**
- ☐ **Lazy Eye**
- ☐ **Redness**
- ☐ **Burning**
- ☐ **Retinal Detachment**
- ☐ **Night Vision Problems**
- ☐ **Loss of Vision**
- ☐ **Eye Discharge**
- ☐ **Double Vision**
- ☐ **Distorted Vision (Halos)**
- ☐ **Excess Tearing/Watering**
- ☐ **Eye Pain/Soreness**
- ☐ **Flashes of Light**
- ☐ **Itchy Eyes**

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

- ☐ **Headaches**
- ☐ **Hearing Loss**
- ☐ **Sinus Pressure**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Heart Disease**
- ☐ **Asthma**
- ☐ **COPD**
- ☐ **Sleep Apnea**
- ☐ **Heart Burn**
- ☐ **Crohn's Disease**
- ☐ **Bladder/Kidney**
- ☐ **Muscle Aches**
- ☐ **Joint Pain**
- ☐ **Arthritis**
- ☐ **Osteoporosis**
- ☐ **Rashes**
- ☐ **Psoriasis**
- ☐ **Migraines**
- ☐ **Seizures**
- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **Diabetes**
- ☐ **Thyroid**
- ☐ **Cirrhosis**
- ☐ **Hepatitis**
- ☐ **Anemia**
- ☐ **Leukemia**
- ☐ **HIV/AIDS**
- ☐ **Lupus**
- ☐ **Allergies**
- ☐ **Stroke**
- ☐ **Autism**
- ☐ **Pregnancy**
- ☐ **Cancer**
- ☐ **Other** ________________

Do you have the following Eye conditions?

- ☐ **Glaucoma**
- ☐ **Macular Degeneration** if yes, do you see a specialist? _________

When was your last eye exam and where? ________________

FOR CLINIC USE ONLY:

Doctor Signature: ____________________

How old are your current glasses? ____

List any prescription medications or over the counter medications or eye drops currently taking (That you do not receive here at the CPN Pharmacy).

____

____

____

Please list any medications you are allergic to:

____

____

List any major EYE surgeries you have had:

____

____

Family Ocular History (Check all that apply)

- ☐ **Glaucoma if yes,** who is 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/vape?

- ☐ **YES**
- ☐ **NO**

Do you use dip/chewing tobacco?

- ☐ **YES**
- ☐ **NO**