

Lake Stevens Vision Clinic

EYE HISTORY

EYE DISEASES: Do you *currently* or *have you ever had* any of the following eye diseases?

	Yes	No			Yes	No		
1	<input type="checkbox"/>	<input type="checkbox"/>	Cataract		6	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes
2	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma		7	<input type="checkbox"/>	<input type="checkbox"/>	Lazy eye
3	<input type="checkbox"/>	<input type="checkbox"/>	Detached retina		8	<input type="checkbox"/>	<input type="checkbox"/>	Injury
4	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic retinopathy		9	<input type="checkbox"/>	<input type="checkbox"/>	_____
5	<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration		10	<input type="checkbox"/>	<input type="checkbox"/>	_____

EYE MEDICATIONS: Please list all of the medicines that you are *currently* using for your eyes NONE

Medication	Eye	Frequency		
_____			_____	
_____			_____	
_____			_____	

GLASSES AND CONTACT LENSES: Do you *currently* wear glasses or contact lenses? NONE

Glasses for distance
 Glasses for reading
 Rigid contact lenses
 Soft contact lenses

FAMILY EYE HISTORY: Have your *parents, siblings or children* had any of the following eye diseases?

	Yes	No			Yes	No		
1	<input type="checkbox"/>	<input type="checkbox"/>	Cataract		4	<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration
2	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma		5	<input type="checkbox"/>	<input type="checkbox"/>	Detached retina
3	<input type="checkbox"/>	<input type="checkbox"/>	Blindness		6	<input type="checkbox"/>	<input type="checkbox"/>	_____

LASER, SURGERY, AND INJURY: List all of your past eye or eyelid *surgeries or laser treatments* NONE

Physician Signature	Date	Physician Signature	Date	Physician Signature	Date
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