Confidential Health History

PAUL VISION INSTITUTE

Thank you for choosing our practice for your eye care needs.

Name _____ **Birthdate** _____

Reason for exam _____

Date of last exam _____ **Name of eye doctor** _____

Do you have the history of the following?

Alzheimer's	Double Vision	Eye Surgery	Poor Near Vision
Blindness	Eyes Burn, Itch or Water	Floaters or Spots	Retinal Detachment
Cataracts	Eye Infection or Disease	Glaucoma	Sensitivity to Light
Cognitive Impairment	Eye Injections	Heart Condition	Severe Pain
Dementia	Eye Injury	High Blood Pressure	Thyroid
Diabetes	Eye Strain	Macular Degeneration	Turned or Lazy Eye

Please list all medications you are currently taking: _____

_____

_____

Do you wear glasses? Yes No

Do you wear contacts? Yes No *If so, what style*?

Soft *Gas Permeable* *Disposable* *Extended Wear* *Bifocal* *Astigmatic* *Tinted*

Are you interested in wearing contacts? Yes No

Signature _____ **Date** _____