PEEPERS OPTICAL

Name:______________________________

Occupation:______________________________

What brings you to the office today?

____

What medications are you currently taking?

____

Are you experiencing any of the following?

❑ Blurred Vision ❑ Frequent Styes
❑ Dry Eyes ❑ Flashes/Floaters
❑ Eye Pain ❑ Poor Night Vision
❑ Light Sensitivity ❑ Itchy Eyes
❑ Headaches ❑ Burning Eyes
❑ Red Eyes ❑ Double Vision
❑ Eye Strain/Tired ❑ Sandy/Gritty Eyes

Visual History

When was your last exam?____________________

Do you wear contact lenses? ❑ Yes ❑ No

If yes, are they comfortable? ❑ Yes ❑ No

How often do you change them?_______ Brand______

Do you sleep in your contacts? ❑ Yes ❑ No

If no, are you interested in contacts? ❑ Yes ❑ No

How old are your glasses?____________________

Have you ever been diagnosed with any of the following:

❑ Keratoconus ❑ Glaucoma
❑ Eye Injury ❑ Cataracts
❑ Macular Degeneration ❑ Retinal Disorder
❑ Lazy Eye ❑Other______________

Eye Surgeries

Have you ever had eye surgery or laser treatments?

❑ Yes ❑ No

Reason:____________________ Date:_________

Date: ______________________________

Medical History

❑ AIDS/HIV ❑ High Cholesterol
❑ Diabetes ❑ Thyroid Disease
❑ Heart Disease ❑ High Blood Pressure
❑ Depression/Anxiety ❑ Cancer (type)_________
❑ Kidney Disorder ❑ Lupus
❑ Sjogren's Syndrome ❑ Other______________

Are you currently pregnant? ❑ Yes ❑ No

If yes, how many months?____________________

Do you have any medication allergies?

____

Do you have any general allergies?

____

Family History

❑ AIDS/HIV ❑ Diabetes ❑ Heart Disease
❑ Thyroid ❑ Allergies ❑ Arthritis
❑ High Blood Pressure ❑ Lupus
❑ Cancer (type)____________ ❑ Other________
❑ Sjogren's Syndrome ❑ Retinal Disorder
❑ Corneal Disease ❑ Macular Degeneration
❑ Cataracts ❑ Color Blind ❑ Lazy Eye
❑ Blindness ❑ Glaucoma

Details:______________________________

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Lifestyle Factors

Have you ever smoked? ❑ Yes ❑ No

If yes, number of years:____________________

Do you currently smoke? ❑ Yes ❑ No

How much alcohol do you drink per week?__________

Do you use any other substances? ❑ Yes ❑ No

If yes, what substance and how often per week?_____

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