Dr. Lauren B. Guzik, OD
Independent Optometrist

PATIENT MEDICAL INFORMATION

Patient Name: ____ **DOB**: ___________

How long ago was your last eye exam? _________________

Do you wear glasses? Yes No Contacts? Yes No for: ☐ Distance ☐ Reading/Computer

Are you currently experiencing any of the following? (circle any that apply):

Burning Itching Watery eyes Red eyes Eye pain Dry eyes Floaters Flashes of light Glare at night

Eyestrain Double vision Difficulty focusing after near work

What is your occupation? ____

How many hours per day (aprox.) do you work on a computer or other digital device? _____________________________

History of eye injury or surgery? Y N
If yes, please describe: ____

Have you ever been diagnosed with an eye disease or condition (e.g. glaucoma, cataracts, dry eye, binocular vision disorder)? Y N
If Yes, please describe: ____

Medical Conditions: Please list any systemic conditions (e.g. high blood pressure, high cholesterol, diabetes, other):
____
____

Medications: Please list ALL medications including over the counter medications, supplements or vitamins *(if you have a printed list of medications, write "see list")*:
____
____

Allergies: Please list any allergies (include medications, environmental, seasonal or foods):
____
____

Family Medical and Ocular History: *(include parents, grandparents, siblings – do not include extended family)*
Please circle any that apply:

Systemic: Diabetes Hypertension Heart Disease Cancer High Cholesterol Auto-Immune Disease

Ocular: Glaucoma Macular Degeneration Cataracts Color Vision Deficiency

Other: ____

Information provided by: ☐ Patient ☐ Parent/Guardian ☐ Power of Attorney ☐ Caretaker/personal aide
Name of person providing information (if other than patient): ____