Brainerd Eyecare Center – Eye History

Name: _____ **Date of Birth:** _____ **Date:** _____

Eye Diseases: Do you now, or have you ever had any of the following diseases?

	YES	NO		Which eye?	R	L		YES	NO		Which eye?	R	L
1	☐	☐	Cataract		____	____	6	☐	☐	Lazy Eye		____	____
2	☐	☐	Glaucoma		____	____	7	☐	☐	Eye or Head Injury		____	____
3	☐	☐	Detached Retina		____	____	8	☐	☐	Spots/Light Flashes		____	____
4	☐	☐	Macular Degeneration		____	____	9	☐	☐	Other		____	____
5	☐	☐	Crossed Eyes		____	____	10	☐	☐	Have you had eye surgery?		____	____

_____

_____

Family Eye History: Have your parents, grandparents, brothers or sisters had any of the following eye diseases?

	YES	NO			YES	NO	
1	☐	☐	Cataract	4	☐	☐	Detached Retina
2	☐	☐	Glaucoma	5	☐	☐	Lazy Eye
3	☐	☐	Macular Degeneration	6	☐	☐	Blindness

_____

_____

Your lifestyle, job, and hobbies affect which options we may suggest for your best visual correction.

What is your occupation? _____

Do you use a computer? ☐ YES ☐ NO

What are your hobbies? _____

Our office recommends polycarbonate lenses for anyone engaging in activities that are hazardous to your eyes. Does your job require safety glasses? ☐ YES ☐ NO