PARKER EYE CARE

A MEMBER OF VISION SOURCE®

S. KATIE PARKER O.D.

EYE HISTORY

Date of Last Eye Exam_____

Currently Wear Glasses?_____

Currently Wear Contacts?_____

Reason for Today's Visit_____

Have you or your family experienced or been treated for any of the following? Circle all that apply.

Cataracts	yes	no	family
Crossed Eye	yes	no	family
Glaucoma	yes	no	family
LASIK or RK	yes	no	family
Lazy Eye	yes	no	family
Macular Degeneration	yes	no	family
Retinal Detachment	yes	no	family

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ❑ Blurry Vision near or distance
- ❑ Burning
- ❑ Discharge
- ❑ Double Vision
- ❑ Dryness
- ❑ Excess Tearing/Watering
- ❑ Eye Infection
- ❑ Eye Pain or Soreness
- ❑ Floaters or Spots
- ❑ Halos
- ❑ Headaches
- ❑ Itching
- ❑ Light Flashes
- ❑ Light Sensitivity
- ❑ Redness
- ❑ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced or been treated for any of the following?

Circle all that apply

AIDS/HIV	yes	no	family
Allergies	yes	no	family
Asthma	yes	no	family
Blood/Lymph Disorder	yes	no	family
Cancer	yes	no	family
Diabetes	yes	no	family
Ears Nose Throat Conditions	yes	no	family
Gastrointestinal Conditions	yes	no	family
Heart Disease	yes	no	family
High Blood Pressure	yes	no	family
High Cholesterol	yes	no	family
Kidney Disease	yes	no	family
Lupus	yes	no	family
Neurological Conditions	yes	no	family
Psychiatric Disorder	yes	no	family
Seizures	yes	no	family
Skin Conditions	yes	no	family
Stroke	yes	no	family
Thyroid Dysfunction	yes	no	family

Current Medications (prescription and OTC) and Dosage_____

_____

_____

_____

Medication Drug Allergies

_____

_____

Height_____ **Weight**_____

Do you smoke?_____ **Have you ever smoked?**____

Are you pregnant or nursing?_____