1) **Patient Name:** _____ **Today's Date:** _____

2) **Primary reason for today's examination:** _____

3) **Do you feel that your vision has changed?** Yes ◯ No ◯

If yes, when did you first notice the change? _____

If yes, has the change been: Sudden ◯ Gradual ◯

4) **Have you had any pain of discomfort in your eyes?** Yes ◯ No ◯

If yes, which eye? Right ◯ Left ◯ Both ◯

5) **Have you had any flashing lights or new floaters?** Yes ◯ No ◯

If yes, when did this start? _____

If yes, does it still happen? Yes ◯ No ◯

6) **Have you had any changes to your health status?** Yes ◯ No ◯

If yes, please explain: _____

7) **Have any of your immediate relatives had a change in their eye health status such as:**

Diabetes ☐ Glaucoma ☐ Macular Degeneration ☐ Cataracts ☐ Other: _____

If yes, what relative(s)? _____

8) **Have you had a change in medication since your last visit?** Yes ◯ No ◯

Medications Added _____ Medications Discontinued _____

9) **Do you wear contact lenses?** Yes ◯ No ◯

If yes, are you happy with your current brand of contacts? Yes ◯ No ◯

If yes, are you wearing contacts today? Yes ◯ No ◯

If not, when did you last wear them? _____

If not, why aren't you wearing them today? _____