BENSON/KENT VISION SOURCE
A MEMBER OF Vision Source

Date _____

Patient Medical History Name _____ DOB _____

Eye History

Date of last eye exam

Currently wear glasses? Yes No

Currently wear contacts? Yes No Interested

Reason for today's visit?

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

	YOU		&/or	Family
Cataracts	Yes	No	&/or	Family
Crossed Eye	Yes	No	&/or	Family
Glaucoma	Yes	No	&/or	Family
LASIK or PRK	Yes	No	&/or	Family
Lazy Eye	Yes	No	&/or	Family
Macular Degeneration	Yes	No	&/or	Family
Retinal Detachment	Yes	No	&/or	Family

Are you currently experiencing, or have you experienced, any of the following? Mark 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 and any family member experienced, or been treated for, any of the following? Circle all that apply.

	YOU		&/or	Family
AIDS/HIV	Yes	No	&/or	Family
Allergies	Yes	No	&/or	Family
Arthritis	Yes	No	&/or	Family
Asthma	Yes	No	&/or	Family
Blood/Lymph Disorder	Yes	No	&/or	Family
Cancer	Yes	No	&/or	Family
Diabetes T1 or T2 A1C_____	Yes	No	&/or	Family
Ears, Nose, Throat Conditions	Yes	No	&/or	Family
Gastrointestinal Conditions	Yes	No	&/or	Family
Heart Disease	Yes	No	&/or	Family
High Blood Pressure	Yes	No	&/or	Family
High Cholesterol	Yes	No	&/or	Family
Kidney Disease	Yes	No	&/or	Family
Lupus	Yes	No	&/or	Family
Neurological Conditions	Yes	No	&/or	Family
Psychiatric Disorder	Yes	No	&/or	Family
Seizures	Yes	No	&/or	Family
Skin Conditions	Yes	No	&/or	Family
Stroke	Yes	No	&/or	Family
Thyroid Dysfunction	Yes	No	&/or	Family

Current Medications (prescription and over the counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?