Ocular History

Last Eye Exam___________________ By Whom: ____________________________________________ OD MD
Did they refer you to Scleral Lens Associates, Inc? ___________________________________________
Do you wear glasses? Y N age of glasses _________ Full time – Part time (Near only / Distance only) Is your vision clear with your glasses? ____________________________________________
Do you wear Contact Lenses? Y N ______ Type of CL? ______________________________________

MAIN REASON FOR VISIT: What are your goals? Needs? ______________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Do your eyes? (Circle if yes)  Burn- Water- Ache- Redness- Itch- Pain- Light sensitivity-
Blur (distance/near) Dryness

Have you ever had an eye injury?  Y N Date / Explain _________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Have you ever eye surgery?  Y N Date / Explain _________________________________
____________________________________________________________________________________

EYE CONDITIONS / DISEASE:  Do you (did you) have or have you ever been told you have:

Cornea Dystrophy  Corneal Transplant  Dry Eyes  Filamentary Keratitis
Keratoconus / Pellucid Marginal Degeneration  Corneal Ulcer  Blepharitis
Refractive Surgery (Radial K / Lasik)  Double Vision  Cataracts Itchy Eyes  Red Eyes
Watery Eyes  Amblyopia (Lazy Eye)  Strabismus  Flashes/Floaters
Optic Nerve (Atrophy - Swelling)  Glaucoma (Narrow angle / Open Angle)
Ortho Keratology / Corneal Refractive Therapy Other
Explain: ________________________________
________________________________________________________________________
________________________________________________________________________

**Family Eye History:** Has any blood relative had any of the above conditions?
Explain _________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Eye Medications**/ Eye drops (list all)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**GENERAL HEALTH HISTORY**
Primary Care Physician ___________________________ Last visit? _________________
Address __________________________________________ City ________________________
State________________________ Zip________ Phone ____________________________

How is your General Health? __________________ Are you pregnant? ____________
Do you use cigarettes/tobacco? Y N _____ packs /day Alcohol Y N _____ drinks /day
Other Substances? __________________________________________________________

Hobbies/Sports ______________________________________________________________
__________________________________________________________________________

**ALLERGIES** FOOD/Airborne List all and reactions
__________________________________________________________________________
__________________________________________________________________________

**ALLERGY to MEDICINES/DRUGS** List all and reactions
__________________________________________________________________________
__________________________________________________________________________
CURRENT MEDICATIONS: List all (and what they are for)

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

VITAMINS / SUPPLEMENTS - List all

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

System Conditions/Disease: Do you have or have you ever had (circle all that apply):

- Graft vs Host Disease
- Sjogren syndrome
- Steven’s Johnsons Syndrome
- Respiratory (Asthma/breathing)
- Arthritis
- Allergy/Immune
- Auto Immune
- Blood disorders
- Cancer
- Cardiovascular
- Nerves
- Diabetes (IDDM/NIDDM)
- Endocrine
- Hypertension
- High Cholesterol
- Gastro-Intestinal
- Musculoskeletal
- Ears/Nose/Throat
- Thyroid
- Skin (Integumentary)
- Psychological
- Migraine
- Other:

Explain: __________________________________________________________________________________________________

_______________________________________________________________________________________________________________

Family Health History: Has any blood relative had any of the above conditions? Explain:

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

Have you had any operations? Y N Kind/Date ________________________________________________________________

_____ I authorize the release of my records and any other information by electronic or other means for medical purposes.

_____ I acknowledge receipt of the Notice of Privacy Policy of Scleral Lens Associates, Inc.

_____ I understand that Scleral Lens Associates, Inc. does NOT accept any insurance and I am responsible for all fees, due on date of service.

_____ I understand that fees for professional services can NOT be reimbursed. If for some reason I am not successful with the designed lens, the cost of the materials can be returned within 90 days of original fit.

Signature ___________________________________________ Date _________________________

Print Name ____________________________ Relation to patient, if pt is a minor ________________________________

Reviewed by Scleral Lens Associates, Inc Optometrist

Sign: ___________________________ (Print)