


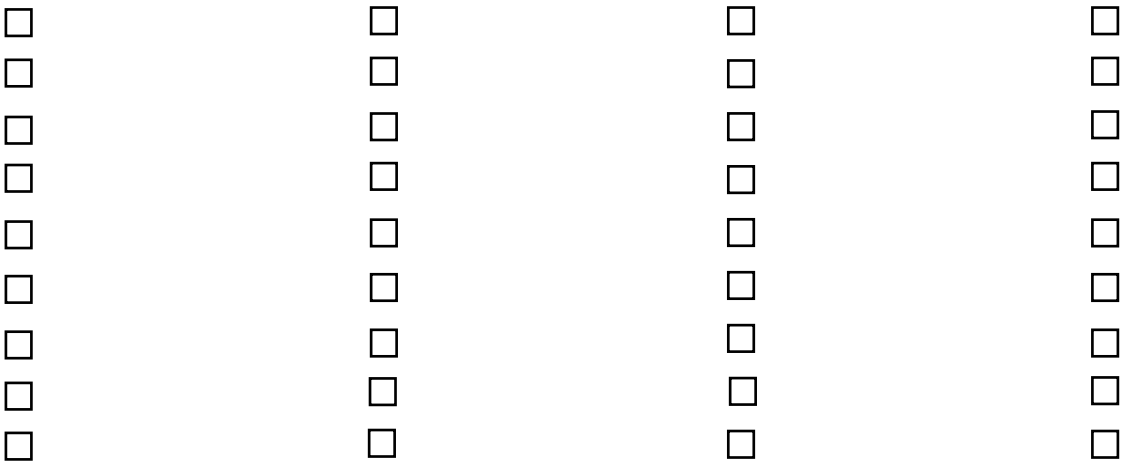

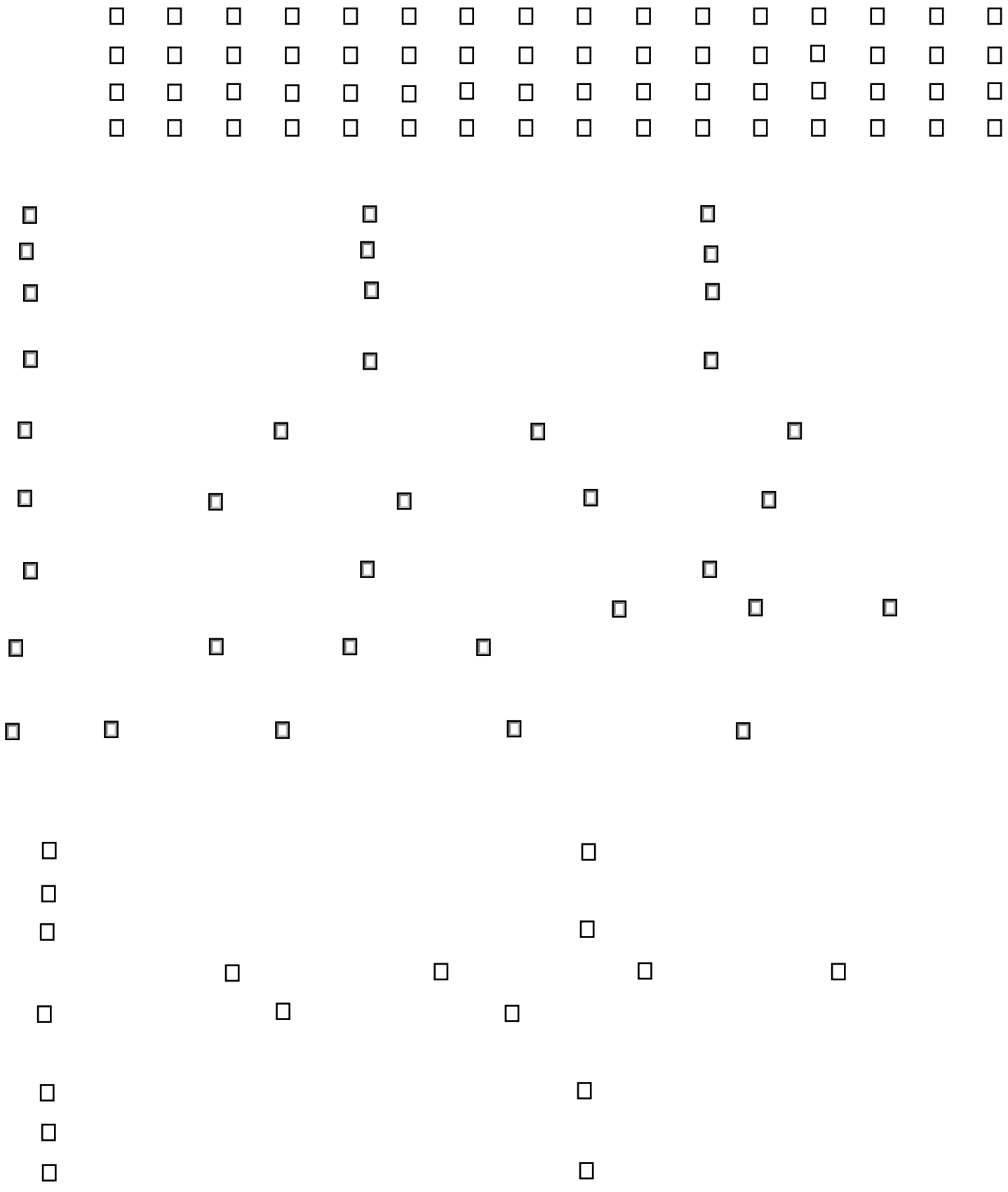

LIFESTYLE CONCERNS

- ☐ Have glare or halos
- ☐ Sensitive to bright light
- colors seem faded out
- ☐ Vision seems like looking through a dirty window
- ☐ Stop driving at night because of vision
- ☐ Vision problems limit patient's daily activities
- ☐ Trouble reading signs while driving at night
- ☐ Prefer not to wear glasses
- ☐ Is interested in LASIK

LIFESTYLE FOR CONTACT LENSES

- ☐ Interested in contact lenses
- ☐ Interested in a contact lens evaluation and fitting
- ☐ Currently wear contact lenses
- ☐ Problems with current contacts
- ☐ Do not have back-eyeglasses

If wears glasses contact are discard ☐ Daily ☐ weekly ☐ 2-3 weeks ☐ monthly ☐ More than 1 month ☐ When they irritate my eyes

If wears contacts I sleeping in them ☐ never ☐ rarely ☐ every night

REVIEW OF SYSTEMS (ROS)

Today, My Eyes Are Experiencing…

☐ Yes ☐ No Double Vision	☐ Yes ☐ No Gritty Feeling	☐ Yes ☐ No Itching Burning	☐ Yes ☐ No Discharge
☐ Yes ☐ No Eye Infection	☐ Yes ☐ No Sties	☐ Yes ☐ No Side Vision Loss	☐ Yes ☐ No Eye Pain
☐ Yes ☐ No Flashers/ Floater	☐ Yes ☐ No Excess Tearing	☐ Yes ☐ No Eye Redness	☐ Yes ☐ No Patching

- ☐ **Yes** ☐ **No** Have you had sudden weight change?
- ☐ **Yes** ☐ **No** Have you had sinus infections?
- ☐ **Yes** ☐ **No** Have you had any shortness of breath or coughing?
- ☐ **Yes** ☐ **No** Have you had any chest pain or palpitations?
- ☐ **Yes** ☐ **No** Are you being treated for high blood pressure?
- ☐ **Yes** ☐ **No** Have you had any vomiting, diarrhea, or constipation?
- ☐ **Yes** ☐ **No** Have you had any blood in your urine?
- ☐ **Yes** ☐ **No** Have worn hard contacts in the last 6 weeks?
- ☐ **Yes** ☐ **No** Have you had any cold or heat intolerance?
- ☐ **Yes** ☐ **No** Have you had any dizziness, emotional disturbances, or headaches?
- ☐ **Yes** ☐ **No** Dermatological - Have you had any rashes or itching?
- ☐ **Yes** ☐ **No** Have you had any back or joint pain?
- ☐ **Yes** ☐ **No** Have you had any bleeding or bruising?
- ☐ **Yes** ☐ **No** - Have you had any recent food or environmental allergic reactions?
- ☐ **Yes** ☐ **No** Are you pregnant, trying to get pregnant or nursing.
- ☐ **Yes** ☐ **No** Have chronic infections?

☐ **No, I am not experiencing any of the above ROS.**

Patient's Name: _____ Birth Date: _____