Eyecare Today

Dr. Robert F. Murray
Optometrist

MEDICAL HISTORY

Reason for today's exam? _____

Please check each item it pertains to you.

___ Glasses
___ Poor Night Vision
___ Poor Far Vision
___ Blurred Vision
___ Double Vision
___ Floaters in Visual Field
___ Flashes of light
___ Halos
___ Gaps/Blind spots

___ Allergies to pollen
___ Sinus problems
___Trouble Reading small print
___ Sensitivity to light (photophobia)
___ Eye Turn
___ Cataracts
___ Diabetes Mellitus
___ Arthritis
___ Hypertension

___ Headaches/Migraines
___ Discomfort/ Pain in or near eye
___ Eye Infection: Redness, Irritation, Tenderness, Discharge
___ Excessive drying or tearing
___ Eye Surgery (type/date of surgery) _____
_____
___ Lung disorders
___ Other _____

___ Allergies to medications: Please List: _____
Medications you are currently taking including over the counter prescriptions: _____
_____

Does anyone in your family have any of the following: (Please indicate relationship to this person)

___ Cataracts _____
___ Glaucoma _____
___ Blindness _____
___ Diabetes Mellitus _____
___ Arthritis _____
___ Hypertension _____
___ Macular Degeneration ___
_____
___ Kidney Disease _____
___ Cancer _____
___ Eye Turn _____
___ Lazy Eye _____
___ Sjogren's Syndrome __
___ Lung Disorders _____
___ Retinitis Pigmentosa ___
___ Other _____

Do you wear Contact Lenses? _____ If yes, are they _____ Soft _____ Hard _____ Gas Permeable
Are you currently happy with the comfort, vision or color of your contacts? _____ If no please explain
_____

If you currently do not wear contacts, would you be interested in wearing them? _____

Dear Patient:

Dr. Murray <u>strongly recommends</u> you have an annual Visual Field Screening.

It takes 45 seconds per eye and screens your visual pathways for 18 diseases either the eye or the brain. The fee for the screening is $20.00.

_____ I DO want the Visual Field Screening

_____ I DO NOT want the Visual Field Screening

Signature _____ Date _____