DATE: ___/___/_____

PATIENT INFORMATION

LAST NAME: _____ **FIRST NAME:** _____ ☐ **M** ☐ **F** **BIRTH DATE:** ____/____/____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

PREFERRED TELEPHONE # __(_____)_____ *HOME WORK CELL* **SECONDARY TELEPHONE #** __(_____)_____ *HOME WORK CELL*

EMPLOYER: _____ **OCCUPATION:**_____ **MARITAL STATUS:** ☐ single ☐ married

REFERRED BY: _____ **EMAIL ADDRESS:** _____ **ETHNICITY:** _____

INSURANCE INFORMATION

VISION INSURANCE PLAN: _____ **MEMBER ID#:** _____

MEDICAL INSURANCE PLAN: _____ **MEMBER ID#:** _____

POLICY HOLDER'S NAME:_____**BIRTH DATE:** ____/____/____ **RELATIONSHIP TO PATIENT:** ☐ Self ☐ Spouse ☐ Parent/guardian

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAY'S EXAM?: _____

_____

AGE OF GLASSES: _____ **DATE OF LAST EYE EXAM:** _____ **FROM DR.** _____ **PREVIOUS PATIENT?** Yes / No

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENTS, PARENTS, BROTHER, SISTER) HAVE ANY OF THESE?

	SELF	RELATIVE	NONE
DIABETES	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐
THYROID CONDITION	☐	☐	☐
HEART DISEASE	☐	☐	☐
HIGH CHOLESTEROL	☐	☐	☐
ASTHMA	☐	☐	☐

	SELF	RELATIVE	NONE
GLAUCOMA	☐	☐	☐
MACULAR DEGEN	☐	☐	☐
RETINAL DISEASE	☐	☐	☐
EYE INJURY	☐	☐	☐
EYE SURGERY	☐	☐	☐
OTHER			

	YES	NO
DO YOU SEE DOUBLE?	☐	☐
FREQUENT HEADACHES?	☐	☐
ARE YOU PREGNANT?	☐	☐

LAST TIME EYES WERE DILATED? _____

PRIMARY CARE DR _____

SMOKING STATUS? ☐ **Daily** ☐ **Sometimes** ☐ **Former** ☐ **Never**

ARE YOU TAKING ANY EYE DROPS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST: _____

_____

ARE YOU TAKING ANY OTHER MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST: _____

_____

DO YOU HAVE ANY ALLERGIES TO MEDICATION OR OTHER? IF YES, PLEASE EXPLAIN _____

_____

ARE YOU HAVING ANY PROBLEMS WITH YOUR VISION? ☐ Far Away ☐ Close Up ☐ In Between

WHAT TYPE OF WORK DO YOU DO? _____ **HOW MANY HOURS PER DAY ARE YOU ON THE COMPUTER?** ___

DO YOUR EYES GET TIRED WHEN READING? ☐ Yes ☐ No **PROBLEMS WITH BRIGHT LIGHTS OR GLARE?** ☐ Yes ☐ No

WHAT TYPE OF SUN PROTECTION DO YOU CURRENTLY WEAR? _____ **HAVE YOU WORN CONTACTS?** ☐ Yes ☐ No

ARE YOU PLANNING TO GET NEW CONTACT LENSES TODAY? ☐ Yes ☐ No ☐ Unsure

WHAT DO YOU LIKE/DISLIKE ABOUT YOUR CURRENT CONTACTS? ☐ Vision ☐ Comfort ☐ Dryness ☐ Color ☐ Itch

WHEN DO YOUR CONTACTS FEEL DRY? _____ **HOW OFTEN DO YOU SLEEP WITH THEM?** _____