WELCOME TO OUR OFFICE

Date____/____/_____

Personal Information

Name Dr. Mr. Mrs. Ms. ____

Date of Birth ____/____/____ **Age**_____ **Sex** ❒ Male ❒ Female **SSN** _____/____/_______

Home Address ________________________**Apt#**______ **Home Phone #** (____)_______________

City _____________________ **State** ______ **Zip** _______ **Work Phone #** (____)_________________

Occupation ______________________ **Employer / School**___________________________________

Guardian (if under 18) ____________________________ **Relationship**_________________________

Address (if different) _____________________________ **City** _____________ **State** ____ **Zip**_________

Marital Status ❒single ❒married ❒divorced ❒ widowed **Spouse's Name**____________________

How did you hear about us? ❒Yellow Pages ❒Direct Mail ❒Location ❒Insurance Book ❒Recommendation

Who may we thank for referring you to us? ________________________________

Medical History

Date of Last Eye Exam ____/____/_____ **Are you Pregnant and/or nursing?** ❒ no ❒ yes

List any and all medications you take: (including oral contraceptives, aspirin, otc meds, and home remedies)

____

____

____

Do you have any allergies? If yes explain:____

____

List any surgeries, hospitalizations, and major injuries you have had: __________________________

____

____

Check the eye conditions you have experienced:

❒ crossed eyes ❒ lazy eye ❒ drooping eyelid ❒ prominent eyes

❒ glaucoma ❒ retinal disease ❒ cataracts ❒ macular degeneration

❒ other eye diseases (please list) ____

❒ other eye injuries (please list) ____

Do you wear glasses? ❒no ❒ yes If yes, how old are your current pair of lenses?______________

Do you wear contacts? ❒no ❒ yes if yes, how old are your current pair of lenses? ______________

Type of contact lenses: ❒rigid ❒soft ❒extended wear ❒ other Are they confortable? ❒ yes ❒ no

Family History

Please note if any family member(parents, grandparents, siblings, chlidren) **has had any of the following:**

Disease	No	Yes	?	Relationship
Blindness	❒	❒	❒	____________
Cataract	❒	❒	❒	____________
Crossed eyes	❒	❒	❒	____________
Glaucoma	❒	❒	❒	____________
Macular Degeneration	❒	❒	❒	____________
Retinal Detachment or Disease	❒	❒	❒	____________

Disease	No	Yes	?	Relationship
Arthritis	❒	❒	❒	____________
Cancer	❒	❒	❒	____________
Diabetes	❒	❒	❒	____________
Heart Disease	❒	❒	❒	____________
High Blood Pressure	❒	❒	❒	____________
Kidney Disease	❒	❒	❒	____________
Lupus	❒	❒	❒	____________
Thyriod	❒	❒	❒	____________

←OVER OVER→

Do you currently, or have you ever had any problems in the following areas:

Eyes	**No**	**Yes**
Loss of Vision	❐	❐
Blurred Vision	❐	❐
Double Vision	❐	❐
Dryness	❐	❐
Distorted Vision/ Halos	❐	❐
Loss of Side Vision	❐	❐
Mucous Discharge	❐	❐
Redness	❐	❐
Gritty Feeling	❐	❐
Itching	❐	❐
Burning	❐	❐
Foreign Body Sensation	❐	❐
Excess Watering/ Tearing	❐	❐
Glare/ Light Sensitivity	❐	❐
Eye pain or Soreness	❐	❐
Chronic Infection of Eyelid	❐	❐
Sties or Chalazion	❐	❐
Flashes/ Floaters in Vision	❐	❐
Tired Eyes	❐	❐

General Health	**No**	**Yes**
Asthma	❐	❐
Chronic Bronchitis	❐	❐
Sinus Congestion	❐	❐
Cancer	❐	❐
Diabetes	❐	❐
Heart Disease	❐	❐
High Blood Pressure	❐	❐
Kidney Disease	❐	❐
Anemia	❐	❐
Thyriod	❐	❐
Lupus	❐	❐
Urinary System	❐	❐
Reproductive System	❐	❐
Immune System	❐	❐
Skin Rash/Irritation	❐	❐
Headaches	❐	❐
Seizures	❐	❐
Psychological Dysfunction	❐	❐
Arthritis	❐	❐

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

____

____

____

Do you . . . . (check box if answer is yes)

- ❐ Work at a computer?
- ❐ Think you might benefit from thinner, lighter lenses?
- ❐ Have an interest in a “Test Drive” of the latest contact lens deisgns?
- ❐ Spend time outdoors? ____Hrs/wk
- ❐ Have prescription sunglasses?
- ❐ Prefer not to wear your glasses at times?
- ❐ Want information on Laser Vision Correction Surgery?
- ❐ Have more than 1 current pair of prescription glasses?
- ❐ Have children?
- ❐ Have family members in need of eyecare?
- ❐ Have problems with glare and halos at night?
- ❐ Enjoy sports that need eye protection?
- ❐ Enjoy outdoor recreation such as golf, tennis, or fishing?
- ❐ Drive and have visual difficulties with glare during the day or night?

Social History

This information is kept strictly confidential. If you prefer, you may discuss this section directly with your doctor.

❐ Yes, I would prefer to discuss this section directly with my doctor.

Do you use tobacco products? ❐ Yes If yes, for how long/how much? ____________________

Do you drink Alcohol? ❐ Yes If yes, amount/how many years? ____________________

Do you use illegal drugs? ❐ Yes If yes, what and for how long? ____________________

Have you ever beee exposed to or infected with: ❐ Gonorrhea ❐ Hepatitis ❐ HIV ❐ Syphilis

Reviewed by: ______________________________ ________________

doctor’s signature date