Name: ____ Sex: M / F Birth Date: _____________

Street Address: _______________________________________ SSN: _______________

City: _______________________________________ State: _____________ Zip Code: ____________________

Phone: Home: (_______) _____________ Work: (_______) _______________ Cell: (_______) ________________

Email: ____

Employer: ___________________________________ Occupation: ________________________

If your insurance is listed under someone else, please provide their name, birthdate, and SSN below.

Name: ___________________________________ Birth Date: __________________ SSN: __________________

Do you currently wear glasses? Y / N ☐ Full Time ☐ Part Time (☐ Distance ☐ Near)

Glasses owned: ☐ Single Vision (Distance / Reading) ☐ Progressives (No-line bifocals)

☐ Bifocals / Trifocals ☐ Computer ☐ Rx Sunglasses ☐ Non-Rx Sunglasses

☐ Sports Glasses for _________________ ☐ Rx Safety Glasses

How old is your current pair of “everyday” glasses? ______________

How many hours per day do you use a computer? _________

Do you experience any eye strain or fatigue with ☐ Computer use ☐ or reading?

Do you experience any visual difficulty driving during ☐ daytime ☐ nighttime ☐ rainy/poor weather?

Do you currently wear contact lenses? Y / N

Type / Brand of contact lenses: _______________________

If not wearing now, have you ever tried to wear contact lenses? Y / N Reason for stopping? _________

I am curious / interested in learning about advances in:
☐ Eyeglasses ☐ Contact Lenses ☐ Laser Vision Correction (LASIK)

Marital Status: ☐ Married (Spouse’s Name:_____________________) ☐ Single ☐ Divorced

Use of alcohol: ☐ None ☐ Rarely ☐ Moderate If Moderate, please elaborate ___________
Use of tobacco: ☐ Never ☐ Previously but not in past _________ years ☐ Yes _______ packs / day
Use of narcotics: ☐ None ☐ Recreational ☐ Chemical dependence

How did you first hear about us? (Circle One): Internet Insurance Driving/Walking by Patient Referral

Name of Referral: ____

Eye History: Are you currently taking any prescription or non-prescription drops / medication for your eyes? Y / N

If so, please list: ____

Have you ever had eye surgery? Y / N
Right eye: surgery for: _________________ Year: ____ Left eye: surgery for: _________________ Year: ____

Have you or do you now have any of the following conditions?

☐ Glaucoma ☐ Macular degeneration ☐ Cataracts ☐ Retinal tear / detachment / hole
☐ Foreign body sensation ☐ Eye Pain ☐ Double vision ☐ Blurred Vision ☐ Crusting
☐ Flashes of light ☐ Floating dark spots ☐ Itching ☐ Burning ☐ Redness ☐ Dryness
☐ Mucus discharge ☐ Light sensitivity ☐ Tearing ☐ Lazy eye / amblyopia ☐ Drooping eyelids

General Health History: Have you been treated or monitored for any of the following?

☐ High blood pressure ☐ Diabetes ☐ Heart disease ☐ Cholesterol ☐ Stroke ☐ Cancer
☐ Autoimmune

Primary Care Doctor: ______________________________________ Date of last physical: _________________________

Are you currently experiencing problems with any of the following? If yes, please explain.

☐ Ear/nose/throat (hearing loss, sinus problem, dry mouth, earache, laryngitis) ________________________________
☐ Fever/fatigue, sudden weight gain or loss ________________________________
☐ Neurological (numbness, headache, seizures, paralysis) ________________________________
☐ Psychiatric (depression, ADD, anxiety, bipolar) ________________________________
☐ Heart (chest pain, angina, irregular heart beat) ________________________________
☐ Respiratory (cough, asthma, shortness of breath, COPD, sleep apnea) ________________________________
☐ Gastrointestinal (abdominal pain, heartburn, ulcer, celiac disease) ________________________________
☐ Urinary (pain when urinating, blood in urine, prostate hypertrophy, STD) ________________________________
☐ Musculoskeletal (joint pain, stiffness or swelling, muscle pain or weakness) ________________________________
☐ Skin problems (eczema, rosacea, psoriasis, rash) ________________________________
☐ Endocrine (thyroid problems, hormone dysfunction) ________________________________
☐ Hematologic / lymphatic (blood disorders, bruising, enlarged glands, anemia) ________________________________
☐ Allergic / immunologic (reactions to foods, seasonal) ________________________________
☐ Other physical condition ________________________________

Family Health: Has anyone in your immediate family been diagnosed with any of the following? If so, which relation?

Blindness _______________________________________
Retinal tear / detachment _________________________
Cataracts _______________________________________
Lazy eye (amblyopia) ______________________________
Glaucoma _______________________________________
Diabetes ____
Macular degeneration ______________________________
Cancer ____

Medications: (prescription and over the counter) ____
____
____

Drug Allergies: Y / N ____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor of any changes in my medical status. ____Date ____________________