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TODAY'S DATE: _____
NAME: _____ PREFERRED: _____ DATE OF BIRTH: _____ SEX: M F
STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____
E-MAIL: _____ SS#: _____
HOME PHONE: _____ CELL: _____ SPOUSE'S NAME: _____
NAME/LOCATION OF PRIMARY PHYSICIAN: _____
VISION INSURANCE: _____ MEDICAL INSURANCE(S): _____
PRIMARY ON INSURANCE _____
PHARMACY YOU USE/LOCATION _____

IF YOU ARE NEW TO OUR OFFICE, HOW DID YOU HEAR ABOUT US?

- Another Doctor _____
- Insurance Listing
- Yellow Pages
- Saw Building/Sign
- Magazine
- Newspaper
- Website
- Friend/Family member _____
- Other _____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? Please check all that apply.

- Stroke/Vascular Disease
- Diabetes
- High Blood Pressure
- High Cholesterol
- Heart Disease
- Kidney/Bladder
- Cancer
- Seizures
- Lung Disease/Asthma
- Headaches/ Migraines
- Pregnant/Breast Feeding
- Psychiatric
- Skin eczema/Rash
- Thyroid Disease
- Arthritis
- Weight loss/Gain
- Autoimmune _____
- Other _____

CURRENT MEDICATIONS? NONE YES PLEASE LIST: (INCLUDE OVER THE COUNTER, HERBS, VITAMINS AND BIRTH CONTROL) _____

DRUG ALLERGIES? NONE YES PLEASE LIST: _____

DO YOU USE: TOBACCO PRODUCTS? YES NO ALCOHOL? YES NO RECREATIONAL DRUGS? YES NO
IF YES, WHAT TYPE? FREQUENCY? HOW LONG? _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING EYE CONDITIONS? Please check all that apply.

- Macular Degeneration
- Glaucoma
- Cataracts
- Blindness
- Turned/Crossed Eyes
- Dry Eyes/Allergies
- Lazy Eye
- Retinal Detachment
- Eye Surgery
- Eye Injury
- Other _____

DO YOU HAVE A FAMILY HISTORY (parents, grandparents, brothers/sisters or children) OF ANY OF THE FOLLOWING DISEASES? Please check all that apply.

- Diabetes
- Glaucoma
- Macular Degeneration
- Retinal Detachment/Disease
- Blindness
- Turned/Crossed Eyes
- Lazy Eye

PLEASE FILL OUT THE BACK ALSO!

WHAT ARE THE REASONS FOR TODAY'S APPOINTMENT? Please check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> Sudden Loss of Vision | <input type="checkbox"/> Watering/Tearing Eyes | <input type="checkbox"/> Floating Spots in Vision |
| <input type="checkbox"/> Distance Blurred Vision | <input type="checkbox"/> Red Eyes | <input type="checkbox"/> Discharge from Eyes |
| <input type="checkbox"/> Near Blurred Vision | <input type="checkbox"/> Eyes Itching/Allergies | <input type="checkbox"/> Matted Eyelids |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Unusual Light Sensitivity |
| <input type="checkbox"/> Frequent Eyestrain | <input type="checkbox"/> Burning/Dry Eyes | <input type="checkbox"/> Foreign Matter in Eyes |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Seeing Flashes of Light | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Eye turning in/out | <input type="checkbox"/> Contact Lens Discomfort | <input type="checkbox"/> Annual/Routine Exam |

LIFESTYLE QUESTIONS?

- Who is your employer? _____
- What is your occupation? _____
- Do you have trouble with your current glasses? _____
- Do you prefer not to wear your glasses at times? _____
- Do you have more than one pair of prescription glasses? _____
- Do you think you might benefit from thinner/lighter lenses? _____
- Are your eyes sensitive to sunlight or bright lights? _____
- Do you have prescription sunglasses? _____
- Do you spend time or work outside? _____ Doing what? _____
- Do your eyes tire quickly while reading? _____
- Do you use a computer? _____ How much? _____
- Do you have trouble with night time driving? (Glare) _____
- Are you interested in Laser Vision Correction? _____
- Do you have other family members in need of eyecare? _____
- Are you involved in activities that may put your eyes in danger? _____ If so, what? _____

CONTACT LENS QUESTIONNAIRE: (Please check all that apply)

- I am not interested in contact lenses.
- I have never worn contacts, but I am interested in my options
- I am not satisfied with the vision of my current contact lenses
- I am not satisfied with the comfort of my current contact lenses
- I currently wear contacts
- If you wear contacts, What type? _____ What solutions? _____
- Do you sleep in your lenses? Y N How often? _____
- Replacement Schedule? Daily Two-Weeks Monthly Quarterly Yearly

THANK YOU!