

**PATIENT INFORMATION**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Gender M / F

Vision Insurance \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Insured name \_\_\_\_\_

Address \_\_\_\_\_

Insured S.S. # \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Patient's S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone \_\_\_\_\_

Employer \_\_\_\_\_

Work/Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_

E-mail Address \_\_\_\_\_

Name of Spouse/Guardian \_\_\_\_\_

Hobbies or Special VISUAL requirements \_\_\_\_\_ How were you referred to this office? \_\_\_\_\_

Do you use your computer for more than 3 hours a day? Laptop desktop both

Are you interested in Laser Surgery?

**CONTACT LENS INFORMATION**

Are you interested in wearing contact lenses? Y / N Are you interested in wearing bifocal contact lenses? Y/N

What brand and power of contact lenses do you wear? \_\_\_\_\_

Have you ever worn contacts? Y / N How long have you worn contacts? \_\_\_\_\_ years. Do you currently wear contacts? Y / N

How old is this pair? \_\_\_\_\_ How many hours a day do you wear contacts? \_\_\_\_\_ Do you ever sleep with your contacts in? Y / N

If yes, how long a period \_\_\_\_\_ List any prior contact lens problems \_\_\_\_\_

Solutions Used: Cleaner \_\_\_\_\_ Saline/Rinse \_\_\_\_\_ Disinfectant/Wetting solution \_\_\_\_\_

Enzyme \_\_\_\_\_ Rewetting drops \_\_\_\_\_ Other \_\_\_\_\_

**VISION HISTORY**

Date of Last Visual Examination \_\_\_\_\_ Doctor/Address \_\_\_\_\_

How old are your glasses? \_\_\_\_\_ What do you like most/ least about them? \_\_\_\_\_

What is the reason for your eye examination today? \_\_\_\_\_

Circle any of the following that you experience:

- |                    |                      |                           |                            |                           |
|--------------------|----------------------|---------------------------|----------------------------|---------------------------|
| Blurred Vision     | Double Vision        | Color Vision Difficulties | Difficulty Seeing at Night | Itchy eyes                |
| Flashes of Light   | Floating black spots | Light Sensitivity         | Headaches or Migraines     | Glare while night driving |
| Blinking/Squinting | Pain in Your Eyes    | Eye tire while reading    | Depth Judgment Difficulty  | Fluctuating vision        |
| Watery Eyes        | Red Eyes             | Dry or sandy Eyes         | Sudden loss/ Fading vision | Burning                   |

Eye treatment, medication, surgery, injury or disease \_\_\_\_\_

**MEDICAL HISTORY**

Are you under care for any disease or condition at this time? Doctor \_\_\_\_\_

Do you or any of your family members have (Please put a check by the following):

Glaucoma? Who? \_\_\_\_\_ High Blood Pressure? Who? \_\_\_\_\_ Cataracts? Who? \_\_\_\_\_

Heart Condition? Who? \_\_\_\_\_ Diabetes? Who? \_\_\_\_\_ Thyroid Condition? Who? \_\_\_\_\_

Asthma/Allergies? Who? \_\_\_\_\_ Walled Eyed/Cross Eyed? Who? \_\_\_\_\_

Please list any allergies \_\_\_\_\_

Please list all the Medications that you are presently taking \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

FEE COLLECTION POLICY: Fees are collected when services are rendered.