

PATIENT INFORMATION

EXAM DATE: / /

LAST NAME _____ FIRST NAME _____ M F BIRTH DATE / /

ADDRESS _____ CITY _____ STATE _____ ZIP _____
PROVINCE _____ POSTAL CODE _____

PREFERRED TELEPHONE NUMBER () HOME WORK CELL (CIRCLE ONE) SECONDARY TELEPHONE NUMBER () HOME WORK CELL (CIRCLE ONE)
WE USE PHONE CALLS TO REMIND PATIENTS OF THEIR APPOINTMENTS. WE WILL USE THE PHONE NUMBER YOU PROVIDE AND THE CALL MAY BE LIVE OR PRERECORDED.

EMPLOYER _____ OCCUPATION _____

REFERRED BY _____ EMAIL ADDRESS _____ SIGNATURE _____

INSURANCE INFORMATION

PLAN NAME _____ GROUP _____

INSURED NAME _____ RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD (CHECK ONE)

INSURED ID# _____ INSURED DATE OF BIRTH / /

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAY'S EXAM? _____

AGE OF PRESENT GLASSES _____ AGE OF SUNGLASSES _____ DATE OF LAST EYE EXAM / / FROM DR. _____ PREVIOUS PATIENT? YES NO

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

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE	YES	NO
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU SEE DOUBLE?	<input type="checkbox"/> <input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CATARACTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT HEADACHES?	<input type="checkbox"/> <input type="checkbox"/>
THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RETINAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT?	<input type="checkbox"/> <input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYE SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYES BEEN DILATED?	<input type="checkbox"/> <input type="checkbox"/> YEAR? _____
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYE INJURY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PRIMARY CARE DR.	_____
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

PLEASE EXPLAIN ANY POSITIVE FINDINGS: _____

ARE YOU TAKING ANY EYEDROPS (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, MEDICATION OR OTHER? IF YES, PLEASE EXPLAIN. _____

ARE YOU PLANNING TO GET NEW GLASSES TODAY? YES NOARE YOU HAVING ANY PROBLEMS WITH YOUR VISION? FAR AWAY CLOSE UP IN BETWEENWHAT DO YOU LIKE/DISLIKE ABOUT YOUR CURRENT EYEWEAR? WEIGHT THICKNESS FIT STYLE SHAPE DURABILITY SIZE COLOR

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

DO YOUR EYES TIRE WHEN READING? YES NOWHEN DO YOU HAVE PROBLEMS WITH BRIGHT LIGHTS OR GLARE? DAY NIGHTWHEN DO YOU NOTICE THIS? ON-COMING HEADLIGHTS COMPUTER SCREEN GLARE FROM WINDSHIELD SUNLIGHTWHAT TYPE OF SUN PROTECTION DO YOU CURRENTLY WEAR? _____ ARE YOU PLANNING TO GET NEW CONTACT LENSES TODAY? YES NOWHAT DO YOU LIKE/DISLIKE ABOUT YOUR CURRENT CONTACTS? VISION COMFORT OXYGEN DRYNESS COLOR ITCH

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

HAVE YOU EVER WORN CONTACTS? YES NO

DO GLASSES GET IN THE WAY OF ANY ACTIVITIES (GOLF, SWIMMING, ETC.)