PATIENT INFORMATION

EXAM DATE: / /

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

ADDRESS _____ CITY _____ STATE PROVINCE _____ ZIP 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	☐	☐	☐	GLAUCOMA	☐	☐	☐	DO YOU SEE DOUBLE?	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	CATARACTS	☐	☐	☐	FREQUENT HEADACHES?	☐	☐
THYROID PROBLEMS	☐	☐	☐	RETINAL DISEASE	☐	☐	☐	ARE YOU PREGNANT?	☐	☐
HEART DISEASE	☐	☐	☐	EYE SURGERY	☐	☐	☐	EYES BEEN DILATED?	☐	☐ YEAR? _____
ASTHMA	☐	☐	☐	EYE INJURY	☐	☐	☐	PRIMARY CARE DR. _____		
CANCER	☐	☐	☐	OTHER _____	☐	☐	☐			

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 HAVING ANY PROBLEMS WITH YOUR VISION? ☐ FAR AWAY ☐ CLOSE UP ☐ IN BETWEEN

WHAT 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 ☐ NO WHEN DO YOU HAVE PROBLEMS WITH BRIGHT LIGHTS OR GLARE? ☐ DAY ☐ NIGHT

WHEN DO YOU NOTICE THIS? ☐ ON-COMING HEADLIGHTS ☐ COMPUTER SCREEN ☐ GLARE FROM WINDSHIELD ☐ SUNLIGHT

WHAT TYPE OF SUN PROTECTION DO YOU CURRENTLY WEAR? _____ ARE YOU PLANNING TO GET NEW CONTACT LENSES TODAY? ☐ YES ☐ NO

WHAT 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.)