

Jerome Agrest, O.D.

Michael Zost, O.D.

Name: (Mr., Mrs., Ms., Dr., Fr., Sr.,) _____ Date of birth: _____ Age: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (H): _____ Phone (W): _____ Phone (C): _____

Social Security # _____ Do you use a computer? _____ Email address: _____

Occupation _____ If enrolled in school, your grade level _____ Employer /School _____

Person responsible for paying the bill: _____ SS# _____ Phone #: _____

Name of Vision Insurance Provider to cover all / part of your bill: _____ Method of Payment: Cash / Check / Charge

EYE / VISION SYMPTOMS:

Last Eye Exam: _____ Reason for this visit: _____

Are you presently having difficulties with your vision? Yes No If yes, briefly describe: _____

Are you experiencing any of the following eye or vision symptoms (please check all that apply):

- | | | | | |
|-------------------------------------------|------------------------------------------|---------------------------------------------|--------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Blur at Distance | <input type="checkbox"/> Redness of Eyes | <input type="checkbox"/> Itching of Eyes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Light Sensitivity |
| <input type="checkbox"/> Blur at Near | <input type="checkbox"/> Burning of Eyes | <input type="checkbox"/> Fluctuating Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Spots or Floaters |
| <input type="checkbox"/> Glare | <input type="checkbox"/> Dryness | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Excessive Tearing | <input type="checkbox"/> Eyestrain |

Are you currently wearing eyeglasses? _____ Are you satisfied with the quality of the vision through these glasses? _____

If you are not satisfied with your glasses, what is it you are unsatisfied with? _____

Do you have a back-up pair of glasses? Yes No Do you own prescription sunglasses? Yes No

To give us a better sense of how you routinely use your eyes, please list any hobbies / sports / recreational activities you participate in on a regular basis.

CONTACT LENSES:

If you are using contact lenses, what type are they? Soft Firm or Gas Permeable Disposable Colored For Astigmatism Bifocals

Are you satisfied with your contact lenses? Yes No If you are not satisfied, what is it you are unsatisfied with? _____

How often do you change your lenses? _____ How many hours a day do you wear your lenses? _____

How old is the pair of contact lenses you are wearing? _____ How many pairs of contact lenses do you have left? _____

What solutions are you using? _____ Do you ever rub your contacts with the solution? Yes No

If you are not wearing contact lenses now, are you interested in trying them? Yes No Have you ever worn contact lenses before? Yes No

GENERAL HEALTH:

When was your last medical exam or physical? _____ Has there been any change in your health since your last eye exam? Please explain?

Are you currently taking any medications, either prescribed or over-the-counter? (Please list any medications including birth control pills, vitamin supplements, or eye drops.)

