

We are pleased to welcome you back to our practice. The following information will aid your doctor in providing the most complete care possible. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to assist you.

PATIENT INFORMATION

Name _____ Age _____ Birth date _____ Date _____
 Occupation / Employer _____ Grade / School _____
 Address Change? _____
 Phone (Home) _____ Phone (Work) _____ Phone (Cell) _____

REASON FOR YOUR VISIT

Please place a "✓" in any that applies to today's visit.

- Annual Check-up / Not Having Any Problems
- Want Stronger Prescription for Distance Tasks
- Want Stronger Prescription for Near Tasks
- Want Bifocals or Reading Spectacles
- Replace Lost or Broken Spectacles
- Need Second Pair Spectacles or Sunglasses
- Need More Contact Lenses
- Would Like to Try Contact Lenses
- Need Reading Glasses Over Contact Lenses
- Trouble Using Eyes Comfortably
- Other _____

Do you wear glasses? No Yes

- All the time Occasionally
- For distance tasks For near tasks Computer

Do you wear contact lenses? No Yes Type _____

Replacement Schedule _____ Hours Worn /Day _____

Pairs Left _____ Solutions used _____

To get a better sense of how you use your eyes, are there any hobbies, sports, or other recreational activities you participate in on a regular basis?

EYE / VISION CONCERNS

Please place a "✓" in any to indicate if you are experiencing any of the following.

- Blurred Vision – Distance
- Blurred Vision – Near
- Burning Eyes
- Crossed Eyes
- Crusty Eyelids
- Double Vision
- Dry Eyes
- Eye Infection / Injury
- Eye Pain
- Eye Strain
- Floaters or Spots
- Fluctuating Vision
- Itching Eyes
- Light Sensitivity
- Poor Night Vision
- Red Eyes
- Seeing Flashes or Halos
- Styes
- Temporary Loss of Vision
- Twitching Eyelid
- Watery Eyes

Date of your last physical _____

	<i>Yourself</i>	<i>Family Members</i>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>
Depression / Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition / or Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (Type _____)	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH HISTORY

Please place a "✓" in any to indicate if you or any blood relative has had any of the following problems (including parents, grandparents, uncle, aunts, or siblings).

	<i>Yourself</i>	<i>Family Members</i>
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell or Trait	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

Are you pregnant? Yes No Number of children _____

Do you use tobacco? Yes No

Do you use alcohol? Yes No

ALLERGIES / SENSITIVITIES

Please place a "✓" in any to indicate if you have any allergies or sensitivities in the categories below.

- Drugs (Please List) _____
- Foods (Please List) _____
- Seasonal / Environmental (Please include which season bothers you most) _____

MEDICATIONS / VITAMINS / SUPPLEMENTS

Please place a "✓" in any to indicate if you use any prescribed or over-the-counter substances in the categories below.

- Medications (Please List) _____
- Vitamins / Supplements (Please List) _____
- Eye Drops (Please List) _____