

Date _____ Mr. Mrs. Miss Ms. Dr. Rev.

Welcome to Our Office

Patient Name _____ Date of Birth _____ Spouse _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Daytime/work Phone _____

Cell Phone _____

How did you hear of our office? _____ Referred by? _____

Are you a legion or VFW member? Y N

Occupation/Grade _____ Any special vision demands (hobbies/work) _____

Have you ever had any surgery or injury to your eyes? Y N If so, please describe _____

Please circle if you have ever had any of the following?

Cataracts / Glaucoma / Lazy Eye / Macular Degeneration / Eye Infections .

Please list any other eye problems: _____

High Blood Pressure / High Cholesterol / Diabetes / Asthma / Emphysema / Heart Problems / Allergies / Thyroid / Arthritis / Skin Problems / Multiple Sclerosis / Stroke

Please list any other health conditions: _____

Please list any Medications, Eye Medications, Vitamins, or Supplements you take.

Any Allergies to any Medications? Y N Please list _____

Do any blood relatives have/had any of the following? Diabetes / Glaucoma / Macular Degeneration / Blindness

Do you smoke? Y N Are you currently pregnant and/or nursing? Y N

Who is your family physician? _____ Town _____ Date of last physical check up? _____

When was your last eye exam? _____ By whom _____ Town _____

Do you currently wear glasses? Y N Contact Lenses? Y N Are you planning on getting new contacts today? Y N

Are you planning to get new glasses today? Y N If Rx changes

Please circle if you **currently** experience any of the following?

Blurry Vision / Frequent Headaches / Dryness, Burning, or Tearing / Double Vision / Floaters or Spots / Trouble Seeing at Night / Sensitivity to Light / Bothered by Glare or Reflections (Especially at Night)

Do you work on a Computer? Y N How much? _____ hrs/week

How much time do you spend in Sun Light? _____ hrs/week Do you wear sun glasses? Y N

This section to be completed by staff _____ VI _____ MI _____ NI _____

Hx Reviewed by _____ Date _____

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