Select a Practitioner Location
*
Select » Patient Information Name
*
Address 1
*
Address 2
City
*
State / Province
*
Select » Zip / Postal Code
*
Home Phone
*
Daytime Phone Cell Phone
Pager Number Fax Number
Email Address
Personal Information Gender
*
Select » Date of Birth (MM/DD/YYYY)
*
Select » Social Security Number (last 4 digits)
Marital Status Select » Employment Select » Employer
Occupation
How were you referred to our office?
*
Select »

Eye History Please check off **any** current conditions you suffer from

- I stopped wearing glasses because:
- I stopped wearing contact lenses because:
- Headaches
- Glare/Light Sensitivity
- Tired Eyes
- Amblyopia (lazy eye)
- Burning
- Dryness
- Watery Eyes
- Eye Pain and/or Soreness
- Foreign Body Sensation

- [ ] Infection of Eye or Lid
- [ ] Itching
- [ ] Mucous Discharge
- [ ] Drooping eyelid(s)
- [ ] Redness
- [ ] Sandy or Gritty Feeling
- [ ] Strabismus (crossed eye)
- [ ] Blurred Vision at Distance
- [ ] Blurred Vision at Near
- [ ] Haloes
- [ ] Double Vision
- [ ] Floaters or Spots
- [ ] Fluctuating Vision
- [ ] Loss of Vision
- [ ] Loss of Side Vision

Glasses History (Skip if you don't wear glasses) What glasses do you own? ☐ Single Vision

- [ ] Bifocals
- [ ] Safety Glasses
- [ ] Backup Glasses
- [ ] Progressive
- [ ] Trifocals
- [ ] Sports Glasses
- [ ] Sunglasses
- [ ] Other _____ How many hours a day do you use a computer?

How many inches away, approximately, do you sit from your computer monitor?

Please check off any current conditions you suffer from

- [ ] I am having problems with my current glasses
- [ ] There are times when I would rather not be wearing glasses
- [ ] I have problems with glare
- [ ] I have problems with night vision
- [ ] I am allergic to nickel (e.g. frames of glasses)
- [ ] I don’t have spare set of glasses
- [ ] My spare glasses have an incorrect prescription
- [ ] My sunglasses are missing UV (ultra-violet) protection

Contact Lens History (Skip if you don't wear contacts) What **brand** of contact lenses do you wear?

How old are your **current** lenses?

How often do you **replace or dispose** your contact lenses?

What brand of solution do you soak your lenses in?

What is your typical **wearing schedule**? Hours/day Days/week Please check off all that apply to you

- [ ] I am having problems with my current contact lenses
- [ ] There are times when I would rather not be wearing contact lenses
- [ ] I am interested in changing or enhancing my eye color
- [ ] I am interested in a non-surgical method of vision correction
- [ ] I am interested in refractive laser surgery
- [ ] I don't have a spare set of contact lenses
- [ ] My spare contact lenses have an incorrect prescription

Medical History When, approximately, was your last **eye exam**?

Where did you get your last **eye exam**?

When, approximately, was your last **physical exam**?

Who is your **primary care physician**?

Do you drink **alcohol**?

Select » Do you **smoke**? Select » Please list all medical conditions you have ever had (Diabetes, High blood pressure, Arthritis, etc.)

Please list all eye conditions you have ever had (Glaucoma, Cataract, Wandering or Lazy eye, Retinal detachment)

Please list any medical or eye conditions that run in your family (blood relatives) (Diabetes, High blood pressure, Cancer, Glaucoma, Macular degeneration, etc.)

Please list all **hospital surgeries** you have ever had

Please list all prescription and over-the-counter medications you take and for what conditions

Please list all **drug allergies** you have

Please check off any current conditions you suffer from

- [ ] Chronic fever, unexpected weight loss/gain, fatigue
- [ ] Ear/nose/throat problems (eg. Hearing loss, sinus problems, sore throat)
- [ ] Heart problems (eg. Chest pain, irregular heart beat, swelling of feet, cold hands or feet)
- [ ] Respiratory problems (eg. Shortness of breath, wheezing, coughing)
- [ ] Gastrointestinal problems (eg. Heartburn, abdominal pain, diarrhea, vomiting)
- [ ] Genitourinary problems (eg. Painful urination, blood in urine, sex organ problems)
- [ ] Musculoskeletal problems (eg. Muscle aches, joint pain, swollen joints)
- [ ] Skin problems (eg. Rashes, excessive dryness, growths or lumps)
- [ ] Neurological problems (eg. Numbness, weakness, headaches, “blackouts”)
- [ ] Psychiatric problems (eg. Depression, anxiety)
- [ ] Endocrine problems (eg. Frequent urination, thirst, feeling hot or cold all the time)
- [ ] Blood/Lymph problems (eg. Bruising, weakness, unusual paleness, swollen glands)
- [ ] Immune problems (eg. Frequent infections, allergic reactions to foods, dust, pollens)

Primary Insurance

Please bring all insurance cards with you to your appointment.

Insurance Company Name

Insurance Company Phone Number

Address

Insured's Name

Identification Number

Group Number

Insured's Date of Birth

Patient's Relation to Insured

Secondary Insurance

If you have coverage through another plan/organization, please fill in the details below.

Insurance Company Name

Insurance Company Phone Number

Address

Insured's Name

Identification Number

Group Number

Insured's Date of Birth

Patient's Relation to Insured

Privacy Policy Health Information Protection

*

I have read and agree to the Privacy Policy

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