



Welcome! Please fill out the following information so that we may have accurate records of your medical and ocular history.

Name: \_\_\_\_\_ M F Other Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Referred By: \_\_\_\_\_ Eye Care Insurance: \_\_\_\_\_  
 Major Medical Insurance: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 What is your main reason for your visit today? \_\_\_\_\_  
 When was your last eye exam? \_\_\_\_\_ Previous eye doctor? \_\_\_\_\_  
 Will you be getting new glasses today? Yes No Will you be getting new contacts today? Yes No  
 How old are your glasses? \_\_\_\_\_ Do you have a backup pair of glasses? Yes No  
 How many hours a day do you use a computer? \_\_\_\_\_  
 Please list hobbies: \_\_\_\_\_ Email address: \_\_\_\_\_

Please check any of the following symptoms you have experienced since your last eye exam:

- Blurred Distance Vision     Double Vision     Flashes of Light     Dry Eyes
- Blurred Near Vision     Headaches     Floaters     Itchy Eyes
- Glare at Night     Eyestrain     Red Eyes     Watery Eyes

Do you or anyone in your family have any of the following?

	Self	Family (Relation)	Medications Taken
Glaucoma	_____	_____	_____
Cataracts	_____	_____	_____
Macular Degeneration	_____	_____	_____
Blindness	_____	_____	_____
Strabismus/Eye Turn	_____	_____	_____
Amblyopia/Lazy Eye	_____	_____	_____
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Heart Disease	_____	_____	_____
Thyroid Disease	_____	_____	_____
High Cholesterol	_____	_____	_____
Allergies	_____	_____	_____
Other (please specify)	_____	_____	_____

Have you ever had any eye injuries or surgeries? \_\_\_\_\_  
 Are you currently wearing contacts? Yes No If yes, what type? \_\_\_\_\_  
 What cleaning regimen do you use? \_\_\_\_\_  
 Are you interested in knowing more about: Laser Vision Correction? \_\_\_\_\_ Contact Lenses? \_\_\_\_\_