## WELCOME TO OUR OFFICE

*Please help us provide you the best possible care by providing the following information.*

Name ______________________ Today's Date ______________________
Nickname ______________________ E-mail Address ______________________
Street ______________________ Social Security Number ______________________
City/State/Zip ______________________ Employer ______________________
Home Phone ______________________ Occupation ______________________
Work Phone ______________________ Date of Birth ____________ Age ________ Sex ________
Cell Phone ______________________ Date of Last Exam ______________________
What is the major purpose of this visit? ______________ Spouse's Work Phone ______________________
Any Problems with your present contact lenses or glasses? ______________________
Spouse's Name ______________________ Parents Work Phone *(If child)* ______________________
Mother's and Father's Name *(If child)* ______________________ Do you participate in a flexible spending account? ❏ Yes ❏ No
Vision Insurance ______________________
How will you settle your account today? ❏ Check ❏ Cash ❏ Credit Card

## MEDICAL HISTORY

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Allergies | Yes | No | Arthritis | Yes | No | Asthma | Yes | No | Cancer | Yes | No |
| Diabetes | Yes | No | Eye Injury | Yes | No | Eye Disease | Yes | No | Heart Disease | Yes | No |
| High Blood | Yes | No | Lazy Eye | Yes | No | Eye Surgery | Yes | No | Cataracts | Yes | No |
| Lung Condition | Yes | No | Glaucoma | Yes | No | Thyroid | Yes | No | Other ______ | | |

## CURRENT MEDICATIONS

Please list all current medications including over the counter meds.

______________________ ______________________
______________________ ______________________
______________________ ______________________

Are you currently under the care of a physician? Yes No

Name of Physician ______________________

## FAMILY MEDICAL HISTORY

| | | | Relationship | | | | Relationship |
|---|---|---|---|---|---|---|---|
| Blindness | Yes | No | ______ | Cataracts | Yes | No | ______ |
| Glaucoma | Yes | No | ______ | Diabetes | Yes | No | ______ |
| Macular Degeneration | Yes | No | ______ | Eye Disease | Yes | No | ______ |

## Do You...

Work at a computer for long periods? ❏ Yes ❏ No
Are there times you'd rather not wear glasses? ❏ Yes ❏ No
Wear Bifocals? ❏ Yes ❏ No
Have problems with eye glasses scratching? ❏ Yes ❏ No
Want information on thinner, lighter lenses? ❏ Yes ❏ No

Want information on Corneal Molding? ❏ Yes ❏ No
(a nonsurgical way to get rid of contacts and glasses)
Have spare glasses in case yours break? ❏ Yes ❏ No
Have prescription sunglasses? ❏ Yes ❏ No
Spend time outdoors? (How much?) ______Hrs./week

Have problems with glare or reflection, particularly when driving at night? ❏ Yes ❏ No
Have you ever worn/are you currently wearing contacts? ❏ Yes ❏ No
What Kind? ______________ Solutions Used? ______________
Interested in a free in-office contact lens trial? ❏ Yes ❏ No

List Hobbies ______________________
______________________
______________________
______________________

## Do You Experience...

❏ Any discomfort
❏ Sensitivity to light
❏ Sudden Loss of Vision
❏ Dryness
❏ Uncomfortable Contact Lenses
❏ Uncomfortable Glasses
❏ Eyes that Burn
❏ Headaches
❏ Double Vision
❏ Floaters or Flashes of Light
❏ Itchy Eyes
❏ Other ______________________

## How did you first hear about our office?

❏ Friend or Relative Who? ______________
❏ Another Health Care Practitioner Who? ______________
❏ Mailing Which? ______________
❏ Employer Which? ______________
❏ Civic Group/Community Event Which? ______________
❏ Yellow Pages Which Directory? ______________
❏ Newspaper Advertisement
❏ Other ______________________