Name _____ **DOB:** _____

E-Mail _____ **Occupation**_____

How did you find our office? Google/Yahoo Search Insurance List Saw Sign
Referred by Friend or Relative _____

What brings you in today? _____

Do you(r) ….
☐...eyes bother you while reading
☐...eyes bother you while on the computer
☐...spend a lot of time outdoors
☐...have prescription sunwear
☐...have more than one pair of current prescription glasses
☐...have family members in need of eyecare
☐...plan on getting new glasses today

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Blurry Vision	☐ Cataracts	☐ Glaucoma	☐ Eye Infections
☐ Crossed eye/Eye turn	☐ Flashes of Light	☐ Headaches	☐ Itchiness
☐ Macular Degeneration	☐ Burning	☐ Tearing/Watery	☐ Retinal Detachment
☐ Uncomfortable Glasses	☐ Corneal Abrasions	☐ Double Vision	☐ Eye Injury
☐ Trouble seeing at night	☐ Grittiness	☐ Iritis/Uveitis	☐ Lazy Eye
☐ Sunlight Sensitivity	☐ Dryness	☐ Floaters/Spots	☐ Other eye disorders_____

Have you had any eye surgery? ☐ Yes ☐ No

Have you ever been diagnosed or treated for the following health problems? Check all that apply

☐ Allergies	☐ Arthritis	☐ Blood/Lymph	☐ Bronchitis
☐ Cancer	☐ Cholesterol	☐ Diabetes	☐ Digestive
☐ Ears/Nose/Throat	☐ Endocrine	☐ Eczema/Rashes	☐ Fatigue
☐ Fevers	☐ Genitourinary	☐ High Blood Pressure	☐ Integument (skin)
☐ Kidney	☐ Muscle/Bone	☐ Neurological	☐ Psychological
☐ Respiratory	☐ Sinus	☐ Throat infections	☐ Thyroid

Name of Primary Physician _____, City_____
Date of Last Medical Exam_____

Current Medications (Rx or Over the Counter) (include eye drops, vitamins and birth control)

Allergic to any medications? ☐ Yes ☐ No If so, what?_____

Date of Last Eye Exam_____ By whom?_____

Family Eye History (Circle all that apply)

Blindness Glaucoma Macular Degeneration