WELCOME TO OUR OFFICE

In order to provide us with a better understanding of your eye care needs. Please complete the following history.
(Please Print)

Name (Last, First. M.I.): _____ Date: _____

Address: _____ Home Phone: _____

City/State/Zip: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Sex: _____ Insurance: _____

Date of last eye exam: _____ SSN (last 4 digits): _____

Have you ever worn glasses? How are they used? ☐ Distance ☐ Near ☐ Full-time

Occupation: _____

Patient E-mail: _____

Your reasons for visiting our office today: (Please check appropriate items)

__General Check-up (no specific problems)	**__Eyes water**	**__Eyes itch**	**__Eyes burn**
__Lost or broken eyeglasses	**__Blurred near vision**	**__Pain in eyes**	**__Eyes feel dry**
__Problems with present contact lenses	**__Want new eyeglasses**	**__Double vision**	**__Light sensitivity**
__Blurred distance vision	**__See "spots" or flashes**	**__Headaches**	**__Glare**
__Eyes feel tired	**__Acute eye injury**		

Contact Lens Information

Do you wear contacts?_____If so, what type? Please check all that apply: ☐ Soft ☐ Gas Permeable/Hard

☐ Daily wear – how many hours a day? _____

☐ Disposable – how often do you dispose of them?_____ ☐ Astigmatism/Toric

☐ Type of contact lens (brand)? _____

Eye and General Health History – past or present (S = Self, F = Family)

__Strabismus/Lazy eye/Amblyopia	**__Cataracts**	**__Heart disease**	**__Hepatitis**
__Allergies (seasonal etc.)	**__Glaucoma**	**__HIV exposure**	**__Eye injury**
__Respiratory problems	**__Cancer**	**__Eye surgery**	**__Diabetes**
__High blood pressure	**__Arthritis**	**__Drug Allergies**	**__Anemia**
__Multiple sclerosis	**__Tuberculosis (TB)**	**__Retinal disorders**	**__Migraines**
__Corneal ulcer	**__Other _____**		

Please list any past eye surgeries _____

Please list any medications or eye drops you are presently taking _____

Please list any medications you are allergic to _____

Are you pregnant/nursing? ___ Yes ___ No