PATIENT'S INFORMATION

NAME: _____
ADDRESS:_____
CITY: _____ State _____ Zip _____
DATE OF BIRTH: _____ / _____ / _____
OCCUPATION:_____
CELL PHONE #: _____-_____-_____
PHONE (OTHER):_____-_____-_____
EMAIL:_____@_____.com

Reason for visit: (check all that apply)

- □ Glasses/General Health Exam
- □ Contact Lens Exam
- □ Lasik Consultation
- □ Emergency (specify) _____
- □ Other _____

INSURANCE INFORMATION

Vision Insurance _____
Subscriber Name _____
Subscriber ID#_____
Subscriber SSN# _____
Subscriber Birthdate _____/_____/_____

□ Check here if you are interested in 0% financing!

Ask about our Prompt Pay discounts!

PATIENT'S EYE HISTORY

Last Eye Exam:_____
Doctor:_____

Do you wear glasses? □ Yes □ No

- □ All the time
- □ Reading Only
- □ Distance Only

Do you wear contact lenses? □ Yes □ No
Brand? _____
Replaced □ Daily
□ 1-2 Weeks
□ Monthly
□ Gas Permeable/Hard

□ Check here if you are interested in LASIK alternatives for all ages.

□ Check here if you are interested in eye drops to help you read

Are you **currently** experiencing any of these symptoms?

- □ Blurry Vision (Far, Computer, or Close)
- □ Headaches (Daily, Weekly, Other)
- □ Red Eyes (started _____days/wks/months/yrs)
- □ Burning (started _____days/wks/months/yrs)
- □ Itching (started _____days/wks/months/yrs)
- □ Tearing (started _____days/wks/months/yrs)
- □ Discharge (started _____days/wks/months/yrs)
- □ Double Vision (started _____days/wks/months/yrs)
- □ Flashes of Light (started _____days/wks/months/yrs)
- □ Seeing Spots (started _____days/wks/months/yrs)
- □ Light Sensitivity (started _____days/wks/months/yrs)
- □ Night Problems (started _____days/wks/months/yrs)
- □ Total Blindness (started _____days/wks/months/yrs)
- □ Other_____

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

- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Diabetic Eye Problems
- □ Eye injury
- □ Retinal Detachment
- □ Blindness
- □ Eye Turn/ Strabismus
- □ Lazy Eye/Amblyopia
- □ Dry Eye
- □ Other_____
  _____
- □ Eye Surgery for:
  _____
  _____
  _____
  _____

DRY EYE QUESTIONAIRE

	ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER
SENSITIVITY TO LIGHTS	4	3	2	1	0
SANDY/GRITTY FEELING	4	3	2	1	0
PAIN/SORENESS	4	3	2	1	0
BLURRED VISION	4	3	2	1	0
MUCUS/CRUSTY EYES	4	3	2	1	0

DRY EYE ACTIVITIES

What activities are affected by your dry eyes?

- □ Cannot read for long periods of time
- □ Vision fluctuates while reading/computer
- □ Eyes are watery/itchy when outside
- □ Eyes feel heavy on the computer
- □ Constantly rubbing eyes
- □ Eyes are red after computer use
- □ Eyes are hard to open in the morning
- □ Contact lens are dry or cannot use

□ Check here if you would like a comprehensive Dry Eye evaluation and treatment plan

Primary Care Physician _____ Pharmacy Name:_____
Telephone #_____ Telephone #_____
Last Physical Exam _____

Have you been diagnosed or treated for the following?

If you have a list of medications, you may provide to the office

Disease	Medication(s)
Diabetes (PRE/Type 1/Type 2)	
Hight Blood Pressure	
High Cholesterol	
Heart Disease	
Stroke	
Cancer – (Please specify)	
Thyroid Disease	
Asthma	
COPD/Breathing Disorders	
Rheumatoid Arthritis	
Depression	
Anxiety	
Attention Deficit Disorder (ADHD)	
Autism	
Lupus	
Other:	
Other:	
Other:	
Currently Pregnant: YES/NO	

☐ ***No Significant Medical History***

Does anyone in your family have any of the following conditions?
Please list the affected family members.

	Father	Mother	Brother	Sister
Macular Degeneration				
Blindness				
Glaucoma				
Eye Turn/Strabismus				
Lazy Eye/Amblyopia				
Myopic Degeneration (High Nearsightedness)				
Cancer				
Diabetes				
High Blood Pressure				
Heart Disease				

☐ ***No Remarkable Family History***

Eye Drops/Medications	***MEDICATION ALLERGIES***	***SOCIAL HISTORY***
1._____ 2._____ 3._____ 4._____ ☐ ***I do not use eyedrops***	1._____ 2._____ 3._____ 4._____ ☐ ***No Known Drug Allergies***	Alcoholic Beverages ☐ None ☐ Rarely ☐ Socially ☐ Daily Smoking ☐ None – No prior history ☐ None – Previous Smoker ☐ 1 pack/day ☐ 2+ packs/day