## *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 Cash 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._____<br>2._____<br>3._____<br>4._____<br><br>□ ***I do not use eyedrops*** | 1._____<br>2._____<br>3._____<br>4._____<br><br>□ ***No Known Drug Allergies*** | Alcoholic Beverages<br>□ None<br>□ Rarely<br>□ Socially<br>□ Daily<br><br>Smoking<br>□ None – No prior history<br>□ None – Previous Smoker<br>□ 1 pack/day<br>□ 2+ packs/day |