



WE ARE GLAD YOU ARE HERE! TO  
ENSURE THE BEST SERVICE POSSIBLE,  
PLEASE ANSWER THE FOLLOWING  
QUESTIONS.



TODAY'S DATE: \_\_\_\_\_  
 NAME: \_\_\_\_\_ PREFERRED: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: M  F   
 STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP \_\_\_\_\_  
 E-MAIL: \_\_\_\_\_ SS#: \_\_\_\_\_  
 HOME PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_  
 NAME AND LOCATION OF PRIMARY PHYSICIAN: \_\_\_\_\_  
 VISION INSURANCE: \_\_\_\_\_ MEDICAL INSURANCE(S): \_\_\_\_\_ PRIMARY \_\_\_\_\_

**PLEASE FILL IN THIS PORTION ONLY IF THE PATIENT IS UNDER 18 YEARS OLD:**

Mother's Name: \_\_\_\_\_  
 Mother's Employer \_\_\_\_\_ Work phone \_\_\_\_\_  
 Mother's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Insurance Company: \_\_\_\_\_  
 Mother's address if different: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_  
 Father's Employer \_\_\_\_\_ Work phone \_\_\_\_\_  
 Father's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Insurance Company: \_\_\_\_\_  
 Father's address if different: \_\_\_\_\_

In the event of an emergency, contact: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone \_\_\_\_\_

**IF YOU ARE NEW TO OUR OFFICE, HOW DID YOU HEAR ABOUT US?**

- Another Doctor \_\_\_\_\_
- Insurance Listing
- Yellow Pages
- Saw Building/Sign
- Magazine
- Newspaper
- Website
- Friend/Family member \_\_\_\_\_
- Other \_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?** Please check all that apply.

- Stroke/Vascular Disease
- Diabetes
- High Blood Pressure
- Heart Disease
- Kidney/Bladder
- Cancer
- Seizures
- Lung Disease/Asthma
- Pregnant/Breast Feeding
- Psychiatric
- Skin eczema/Rash
- Thyroid Disease
- Arthritis
- Autoimmune \_\_\_\_\_
- Other \_\_\_\_\_

**CURRENT MEDICATIONS?** NONE  YES  PLEASE LIST: (INCLUDE OVER THE COUNTER, HERBS, VITAMINS, BIRTH CONTROL) \_\_\_\_\_

**DRUG ALLERGIES?** NONE  YES  PLEASE LIST: \_\_\_\_\_

DO YOU USE: TOBACCO PRODUCTS? YES  NO  ALCOHOL? YES  NO  RECREATIONAL DRUGS? YES  NO   
 IF YES, WHAT TYPE? FREQUENCY? HOW LONG? \_\_\_\_\_

**PLEASE FILL OUT BACK ALSO.**

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING EYE CONDITIONS?**Please check all that apply.

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Turned/Crossed Eyes | <input type="checkbox"/> Eye Surgery |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Dry Eyes/Allergies  | <input type="checkbox"/> Eye Injury  |
| <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Lazy Eye            | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blindness            | <input type="checkbox"/> Retinal Detachment  |                                      |

**DO YOU HAVE A FAMILY HISTORY (parents, grandparents, brothers/sisters or children) OF ANY OF THE FOLLOWING DISEASES?** Please check all that apply.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Retinal Detachment/Disease | <input type="checkbox"/> Turned/Crossed Eyes |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Blindness                  | <input type="checkbox"/> Lazy Eye            |
| <input type="checkbox"/> Macular Degeneration |   |  |

**WHAT ARE THE REASONS FOR TODAY'S APPOINTMENT?** Please check all that apply.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Sudden Loss of Vision   | <input type="checkbox"/> Watering/Tearing Eyes   | <input type="checkbox"/> Floating Spots in Vision  |
| <input type="checkbox"/> Distance Blurred Vision | <input type="checkbox"/> Red Eyes                | <input type="checkbox"/> Discharge from Eyes       |
| <input type="checkbox"/> Near Blurred Vision     | <input type="checkbox"/> Eyes Itching/Allergies  | <input type="checkbox"/> Matted Eyelids            |
| <input type="checkbox"/> Frequent Headaches      | <input type="checkbox"/> Eye Pain                | <input type="checkbox"/> Unusual Light Sensitivity |
| <input type="checkbox"/> Frequent Eyestrain      | <input type="checkbox"/> Burning/Dry Eyes        | <input type="checkbox"/> Foreign Matter in Eyes    |
| <input type="checkbox"/> Double Vision           | <input type="checkbox"/> Seeing Flashes of Light | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Eye turning in/out      | <input type="checkbox"/> Contact Lens Discomfort | <input type="checkbox"/> Annual/Routine Exam       |

**LIFESTYLE QUESTIONS?**

Who is your employer? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Do you have trouble with your current glasses? \_\_\_\_\_

Do you prefer not to wear your glasses at times? \_\_\_\_\_

Do you have more than one pair of prescription glasses? \_\_\_\_\_

Do you think you might benefit from thinner/lighter lenses? \_\_\_\_\_

Are your eyes sensitive to sunlight or bright lights? \_\_\_\_\_

Do you have prescription sunglasses? \_\_\_\_\_

Do you spend time or work outside? \_\_\_\_\_ Doing what? \_\_\_\_\_

Do your eyes tire quickly while reading? \_\_\_\_\_

Do you use a computer? \_\_\_\_\_ How much? \_\_\_\_\_

Do you have trouble with night time driving? (Glare) \_\_\_\_\_

Are you interested in Laser Vision Correction? \_\_\_\_\_

Do you have other family members in need of eyecare? \_\_\_\_\_

Are you involved in activities that may put your eyes in danger? \_\_\_\_\_ If so, what? \_\_\_\_\_

**CONTACT LENS QUESTIONNAIRE:** (Please check all that apply)

- I am not interested in contact lenses.
- I have never worn contacts, but I am interested in my options
- I am not satisfied with the vision of my current contact lenses
- I am not satisfied with the comfort of my current contact lenses
- I currently wear contacts

If you wear contacts, What type? \_\_\_\_\_ What solutions? \_\_\_\_\_

Do you sleep in your lenses? Y  N  How often? \_\_\_\_\_

Replacement Schedule?  Daily  Two-Weeks  Monthly  Quarterly  Yearly

**THANK YOU!**