Appointment:

Name: **(Nickname):**_____ **DOB:(**

Address: **Phone:(**

Insurance **Responsible Party: (**_____

LAST FOUR DIGITS OF SS#_____

Since your last eye examination in our office have you had any EYE injuries, infections or surgeries? YES NO If yes, please explain_____

Primary Physician_____

Please check all conditions that **currently** apply **while wearing glasses or contacts**:

___No complaints or concerns	___Dry eyes	___Sensitivity to light
___Poor distance and near vision	___Floaters or spots	___Double vision
___Poor distance vision	___Flashes of light	___Bothered by night driving
___Poor near vision	___Redness	___Bothered by glare
___Problems with computer vision	___Eyes water	
___Eye strain	___Eyes burn or itch	
___Mattering	___Eye turn	

Do you or anyone in your immediate family have a history of the conditions listed below? Check all that apply.

	YOU	RELATIVE		YOU	RELATIVE
Allergies(**seasonal**)	___	___	Neurological Conditions	___	___
Heart Disease	___	___	Breathing Problems	___	___
High Blood Pressure	___	___	Thyroid Problems	___	___
Diabetes	___	___	**Glaucoma**	___	___
Digestive Conditions	___	___	**Macular Degeneration**	___	___
Ear/Nose/Throat Conditions	___	___	**Amblyopia (lazy eye)**	___	___
Diseases of the blood	___	___	**Crossed Eyes**	___	___
Immune Conditions	___	___	**Retina Detach/Tear**	___	___
Skin Problems	___	___	**Cataracts**	___	___
Muscle/Joint Conditions	___	___	Other:_____	___	___

Please list current medications and/or vitamins_____

_____

Medications you are **allergic** to _____

Are you experiencing headaches? YES NO If yes, how often? _____

Are there any particular things that trigger your headaches?_____

Do you smoke? YES NO QUIT (when?_____)

Alcohol consumption? Never Occasionally 1-2 per day >2 per day

For women only: Are you pregnant or nursing? YES NO

Do you currently wear contacts? YES NO Do you want to be fit with contacts? YES NO
(If yes please keep reading)

A yearly contact lens evaulation is necessary to renew and buy new contact lenses. The contact lens exam ***is not*** part of the comprehensive eye health or refractive vision test examination. Contact lens patients require additional testing, time, measuring, and monitoring to evaluate the design and fit of their current lenses, the health of the eye as it relates to contacts or in the case of a new wearer, their suitability to wear contacts. The contact lens fee varies with complexity of the lens design and diagnostic fitting time. Insurance or vision benefit plans may contribute an allowance.

Signature:_____ Date:_____