

General Information

Date: ____/____/____

Last Name _____	First Name: _____	M _____	DOB: ____/____/____
M or F _____	SSN: ____/____/____	Marital Status: Married / Single / Divorced / Widowed	
Address: _____		City: _____	State: _____ Zip: _____
Home Ph: () _____	Work Ph: () _____	Cell Ph: () _____	
Employer/School: _____		Occupation/School Grade: _____	
E-mail Address: _____		Sports/Hobbies: _____	
Emergency Contact: _____		Relation: _____	Phone #: () _____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam: ____/____/____ Primary Physician/Clinic: _____

Date of Last Eye Exam: ____/____/____ Clinic/Eye Doctor's Name: _____

Do you wear glasses? Yes/No/All the time/Sometimes/Work Only/Reading only/Driving only

How old are your present glasses: _____ Do you wear prescription Sun Wear: Yes/No

Do you wear contacts? Yes No Type: _____ Solution Used: _____

Wearing schedule: **Daily Overnight** Replacement schedule: **Daily 2 week Monthly Yearly**

Have you ever had eye injuries? Yes No Which Eye? _____

Have you ever had eye surgeries? Yes No Why? _____

Have you used eye medication? Yes No Why? _____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed? _____

Glaucoma: Yes/No When were you diagnosed? _____

Macular Degeneration: Yes/No When were you diagnosed? _____

What are your visual symptoms (with or without glasses or contacts)? Please circle any that apply:

Please indicate Right, Left or Both, along with severity 1(Low) 2 (Moderate) 3 (High)

In Example: [2] Eye Strain R L (B) This example indicates a moderate severity in both eyes

- | | | | | | |
|-----------------------------|-------|-----------------------|-------|--------------------------|-------|
| [] Blurred Vision/Distance | R L B | [] Dry Eyes | R L B | [] Headaches | R L B |
| [] Blurred Vision/Near | R L B | [] Red Eyes | R L B | [] Migraine Headaches | R L B |
| [] Double Vision | R L B | [] Watery Eyes | R L B | [] Loss of Vision | R L B |
| [] Eye Strain | R L B | [] Wandering eye | R L B | [] Crossed Eyes | R L B |
| [] Eye Infections | R L B | [] Mucus Discharge | R L B | [] Light Sensitive | R L B |
| [] Eye Pain/Soreness | R L B | [] Floaters or Spots | R L B | [] Sandy/Gritty Feeling | R L B |
| [] Tired eyes | R L B | [] See Flashes | R L B | [] Poor Color Vision | R L B |
| [] Burning Eyes | R L B | [] See Halos | R L B | [] Droopy Lid | R L B |
| [] Itchy Eyes | R L B | [] Poor Night Vision | R L B | | |