* Name_____ * Phone_____ *Date_____

* Home Address_____ City_____ St._____ Zip _____

Age_____ Birthdate_____ Social Security #_____

Names and ages of children _____ Name of Spouse (or Parent)_____

Where Employed _____ Occupation _____ Work Phone#_____

Cell Phone#_____ Email(optional) _____

* What do you have to see in your work? _____

Method of Payment: Local Check Cash Visa MasterCard Debit American Express

Insurance Coverage? ☐ No ☐ Yes **Program Name** _____

Family Physician _____ *How long since last physical? _____

How would you rate your general health? ☐ Good ☐ Fair ☐ Poor _____

Do you wear glasses? ☐ Yes ☐ No **Do you wear contact lenses?** ☐ Yes ☐ No **What kind** _____

Date of last eye exam _____ **Referred by** _____

***What is the main reason for seeing the Doctor?** _____

_____

_____

_____

Special activities or interests _____

PLEASE CHECK OR CIRCLE THE ANSWERS TO THE FOLLOWING QUESTIONS

	y	n
Is your vision blurred at a distance?	☐	☐
Is your vision blurred at reading or close distances?	☐	☐
Does your present vision interfere with your work or activities?	☐	☐
Do you have headaches?	☐	☐
Are you bothered by eye strain or discomfort? When _____	☐	☐
Do your eyes itch, burn, sting, water, or get red? (circle)	☐	☐
Do you see double?	☐	☐
Have you ever had to do eye exercises?	☐	☐
Does sunlight in general bother you?	☐	☐
Do you have trouble seeing clearly at night?	☐	☐
Have you ever had an eye infection?	☐	☐
Have you ever had an eye injury or eye surgery?	☐	☐
Are you color blind?	☐	☐
Is this visit concerning contact lenses?	☐	☐

	y	n
* Do you have any health problems now?	☐	☐
* Are you taking ANY medication now?	☐	☐
Do you have any allergies?	☐	☐
Do you have any reactions to any medicines or shots?	☐	☐
Are you currently under any unusual emotional strain?	☐	☐
Is your blood pressure normal?	☐	☐
Have you ever had thyroid trouble?	☐	☐
Have you ever been told you have diabetes?	☐	☐
Is there any history of diabetes in your family?	☐	☐
Is there any history of blindness in your family?	☐	☐
Is there any history of glaucoma in your family?	☐	☐
Is there any history ot cataracts in your family?	☐	☐
Is there any history of crossed or turned eyes in your family?	☐	☐
Is there any history of lazy eyes in your family?	☐	☐
Is there a history of cancer in family or self? Explain	☐	☐

Remarks _____

_____

_____