

WELCOME TO OUR OFFICE

Name: _____ Today's Date: _____

When was your last eye exam? _____

Do you currently receive any form of Government coverage for your eyewear and/or eye exam? If yes, Please list _____

What is your chief concern today? _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

Referred by a friend or relative? If so, who? _____

Referred by another health care provider? If so, who? _____

Civic Group or Community Event? If so, which? _____

Television Yellow Pages Office Signage Welcome Letter

ABOUT YOU AND YOU EYEWEAR

What is your occupation? _____

What hobbies and sports do you enjoy? _____

How much time do you spend outdoors in an average week? _____

Do you have an east/west commute during the day? YES NO

Do you use a computer? YES NO If yes, on average, how many hrs. a day? _____

Do you have an additional pair of glasses as a back up? YES NO

Do you have sunglasses filtering 100% UV light? YES NO

Do you have problems with light or reflections, most noticeably at night? YES NO

Are there occasions when you would rather not wear glasses? _____

Have you ever, or are you currently wearing contact lenses? YES NO

If yes, what type? _____

Are you interested in contact lenses? YES NO

MEDICAL HISTORY

Has a **Blood Relative** been diagnosed with diabetes, glaucoma, macular degeneration, blindness or any other medical conditions? If so, please list: _____

Have you had any of the following?

Lazy Eye Cataracts High Blood Pressure Asthma
 Eye Injury Glaucoma Heart Disease Arthritis
 Eye Disease Diabetes Thyroid Disease Allergies
 Eye Surgery Kidney Disease Sinus Problems

Do you experience any of the following?

Burning Gritty Sensation Nausea Spots Pain
 Itching Excessive Tearing Dizziness Flashes of Light Headaches
 Redness Double Vision Fainting Sensitivity to Light Sudden Loss of Vision
 Dryness Blurred Vision Floaters Night Blindness

Please list any ongoing health concerns _____

Excluding regular health check ups, please list any ongoing health conditions _____

Please List ALL current medications including prescription, over the counter, vitamins, and herbal supplements. _____

FOR OFFICE USE ONLY (PLEASE DO NOT WRITE BELOW THIS LINE)

KNOWN ALLERGIES _____

Test Administrator: _____ Seated By: _____