

# WELCOME BACK TO OUR OFFICE

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of your last eye exam: \_\_\_\_\_

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

Are your current glasses from this office? (Please circle) YES NO NOT APPLICABLE

What is your main concern today? \_\_\_\_\_

Are there occasions when you would rather not wear glasses? \_\_\_\_\_

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

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

What hobbies and/or 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

Have you ever or are you now wearing contact lenses? YES NO

If yes, what type? \_\_\_\_\_

Are you interested in Contact Lenses? YES NO

## ABOUT YOUR EYEWEAR

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 notably at night? YES NO

## FAMILY MEDICAL HISTORY

Since last visiting our office has a **Blood Relative** been diagnosed with diabetes, glaucoma, macular degeneration, blindness or any other medical conditions? If so, please list: \_\_\_\_\_

## YOUR MEDICAL HISTORY

Do you experience any of the following? (Check those that apply)

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Burning          | <input type="checkbox"/> Excessive Tearing | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Night Blindness       |
| <input type="checkbox"/> Itching          | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Floaters             | <input type="checkbox"/> Blurred Vision        |
| <input type="checkbox"/> Redness          | <input type="checkbox"/> Pain              | <input type="checkbox"/> Spots                | <input type="checkbox"/> Double Vision         |
| <input type="checkbox"/> Dryness          | <input type="checkbox"/> Nausea            | <input type="checkbox"/> Flashes of Light     | <input type="checkbox"/> Sudden Loss of Vision |
| <input type="checkbox"/> Gritty Sensation | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Sensitivity to Light |  |

Please list any ongoing health concerns: \_\_\_\_\_

Excluding routine check-ups. Do you have any health conditions for which you are presently being monitored? If yes please list: \_\_\_\_\_

Please list all current medications including prescription, over the counter, vitamin, and herbal supplements:

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## FOR OFFICE USE ONLY DO NOT WRITE BELOW THE LINE

### KNOWN ALLERGIES

TEST ADMINISTRATOR: \_\_\_\_\_ SEATED BY: \_\_\_\_\_