



Please help us keep our records current by updating this form at each visit.

First Name MI Last Name Date of Birth

Mailing Address City State Zip Code

Home Phone # Cell Phone # E-mail Address (used for recall purposes)

Responsible party & relationship if patient is a dependent

How did you hear about us? (Examples: walk-in, referral, internet search, previous Costco exam, insurance)

Approx. date of last eye exam? Location of last eye exam?

Main purpose of today's visit?

Do you currently wear glasses? Do you currently wear contact lenses?

Are you interested in wearing contact lenses? Lasik vision correction?

Ocular Health - please check any of the following that apply to you:

- Floaters, Flashes, Dryness, Redness, Pain, Itching, Eye strain, Double Vision, Lasik, Injury, Cataract, Glaucoma, Macular Degeneration, Other:

Please list medications you are taking and what they are being taken for:

Please list any significant medical conditions not listed above:

Please list any medications that you are allergic to:

Family History - please check any of the following that are in your direct bloodline:

- Diabetes, Glaucoma, Macular degeneration, Blindness, Other:

Federal law requires you be made aware of your privacy rights regarding personal medical information. By signing you acknowledge that you have been offered a copy of the federal HIPAA privacy policies, and that you have read and understand the exam fee policy sheet.

Patient/Guardian's Signature

Date