Chester Eye Center

PATIENT HISTORY AND INFORMATION

Name

Height ____ ____

Weight ____ ◉ lbs ○ kg What was your last blood pressure reading? ____ Date Taken? ____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Method of Tobacco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No

SPECTACLE LENS HISTORY

Are you planning to order glasses today? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No Since _____

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No _____

Do you wear sunglasses? ○ Yes ○ No Are your sun glasses your current prescription ? ○ Yes ○ No

Are you interested in prescription/nonprescription sunglasses today? ○ Yes ○ No

Do you use a computer? ○ Yes ○ No

Do you drive? ○ Yes ○ No

Do you have glare problems? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings)
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (gardening, woodworking, welding)
☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

Are you planning to order contact lenses today? ○ Yes ○ No

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? _____

Do you currently wear contact lenses? ○ Yes ○ No Since _____

Type and brand of contact lenses _____

How many hours/day ? _____

Are you having trouble with your current contact lenses? ○ Yes ○ No