

# WELCOME TO OUR OFFICE

Please help us provide you the best possible care by providing the following information.

Name \_\_\_\_\_  
Nickname \_\_\_\_\_  
Street \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
What is the major purpose of this visit? \_\_\_\_\_  
Any Problems with your present contact lenses or glasses? \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Mother's and Father's Name (If child) \_\_\_\_\_  
Vision Insurance \_\_\_\_\_  
How will you settle your account today?  Check  Cash

Today's Date \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Date of Last Exam \_\_\_\_\_  
Spouse's Work Phone \_\_\_\_\_  
Parents Work Phone (If child) \_\_\_\_\_  
Do you participate in a flexible spending account?  Yes  No  
 Credit Card  Payment Plan

## MEDICAL HISTORY

Allergies	Yes	No	Arthritis	Yes	No	Asthma	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	Eye Injury	Yes	No	Eye Disease	Yes	No	Heart Disease	Yes	No
High Blood	Yes	No	Lazy Eye	Yes	No	Eye Surgery	Yes	No	Cataracts	Yes	No
Lung Condition	Yes	No	Glaucoma	Yes	No	Thyroid	Yes	No	Other	_____	

## CURRENT MEDICATIONS

Please list all current medications including over the counter meds.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently under the care of a physician? Yes No

Name of Physician \_\_\_\_\_

## FAMILY MEDICAL HISTORY

	Relationship		Relationship		
Blindness	Yes No	_____	Cataracts	Yes No	_____
Glaucoma	Yes No	_____	Diabetes	Yes No	_____
Heart Disease	Yes No	_____	Eye Disease	Yes No	_____

## Do You...

Work at a computer for long periods?  Yes  No  
Are there times you'd rather not wear glasses?  Yes  No  
Wear Bifocals?  Yes  No  
Have problems with eye glasses scratching?  Yes  No  
Want information on thinner, lighter lenses?  Yes  No  
Want information on Corneal Molding?  Yes  No  
(a nonsurgical way to get rid of contacts and glasses)  
Have more than one pair of glasses?  Yes  No  
Have prescription sunglasses?  Yes  No  
Spend time outdoors? (How much?) \_\_\_\_\_ Hrs./week  
Have problems with glare or reflection, particularly when driving at night?  Yes  No  
Have you ever worn/are you currently wearing contacts?  Yes  No  
What Kind? \_\_\_\_\_ Solutions Used? \_\_\_\_\_  
List Hobbies \_\_\_\_\_  
Interested in a free in-office contact lens trial?  Yes  No

## Do You Experience...

Any discomfort  Dryness  Nausea  Floaters or Flashes of Light  
 Sensitivity to light  Uncomfortable Contact Lenses  Headaches  Other \_\_\_\_\_  
 Sudden Loss of Vision  Uncomfortable Glasses  Double Vision

## How did you first hear about our office?

Friend or Relative Who? \_\_\_\_\_  
 Another Health Care Practitioner Who? \_\_\_\_\_  
 Mailing Which? \_\_\_\_\_  
 Employer Which? \_\_\_\_\_  
 Civic Group/Community Event Which? \_\_\_\_\_  
 Yellow Pages Which Directory? \_\_\_\_\_  
 Newspaper Advertisement  
 Other \_\_\_\_\_