L'Optique
OPTOMETRY

Today's Date_____

PERSONAL INFORMATION

LAST NAME | FIRST NAME | MI

ADDRESS | CITY | STATE | ZIP

BIRTHDAY | AGE | EMPLOYER | OCCUPATION

INSURANCE INFORMATION

VISION INSURANCE | SUBSCRIBER'S NAME

SUBSCRIBER'S SSN | SUBSCRIBER'S DOB | SUBSCRIBER'S EMPLOYER

MEDICAL INSURANCE | SUBSCRIBER'S NAME

SUBSCRIBER'S SSN | SUBSCRIBER'S DOB | SUBSCRIBER'S EMPLOYER

HEALTH HISTORY

Date of Last Physical _____ Name of Primary Care Physician _____

Do You Currently Have Or Had Any Of The Following Conditions?

☐ Diabetes ☐ Respiratory Problems ☐ Cancer
☐ Hypertension ☐ Stroke/Neurological ☐ Kidney Problems
☐ High Cholesterol ☐ Cardiovascular Problems ☐ Skin Disorders
☐ Thyroid Problem ☐ Blood Clot/Bleeding ☐ Are You Pregnant?
☐ Anxiety/Depression ☐ Sickle Cell/Anemia ☐ HIV/AIDS
☐ Hepatitis ☐ Tuberculosis ☐ Arthritis
☐ Other (Please Explain) _____

Date of Last Eye Exam _____

Have You Ever Been Treated For Or Diagnosed With Any Of The Following?

☐ Cataracts ☐ Glaucoma ☐ Eye Infection
☐ Amblyopia/Lazy Eye ☐ Macular Degeneration ☐ Eye Surgery
☐ Strabismus/Crossed Eye ☐ Retinal Problems ☐ Eye Trauma

Do You Experience Any Of The Following eye Conditions?

☐ Blurred Vision ☐ Burning ☐ Flashes/Floaters in Vision
☐ Double Vision ☐ Dry Eyes ☐ Glare/Light Sensitivity
☐ Excess Tearing/Water ☐ Itching ☐ Loss of Side Vision

Do You Have A Family History Of The Following?

☐ Diabetes ☐ Glaucoma ☐ Retinal Detachment
☐ Strabismus/Crossed Eyes ☐ Amblyopia/Lazy Eye ☐ Hypertension
☐ Blindness ☐ Macular Degeneration ☐ Cataracts

LIST ALL CURRENT MEDICATIONS:	LIST ALL KNOWN ALLERGIES:

CONTACT INFORMATION

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

What is the best way for us to reach you?
☐ **Home** ☐ **Work** ☐ **Cell** ☐ **Email**

How did you hear about us?
☐ **Local Paper** ☐ **Flyer** ☐ **Other** _____

SOCIAL HISTORY

- Do you smoke? ☐ Yes ☐ No
  If Yes, amount/how long? _____
- Do you drink alcohol? ☐ Yes ☐ No
  If Yes, amount/how long? _____
- Do you use any recreational drugs?
  ☐ Yes ☐ No

LIFESTYLE QUESTIONS

- Do you experience difficulty with any of the following visual demands?
  ☐ Reading Small Print ☐ Computer work
  ☐ Golf ☐ Night Driving
  ☐ Music ☐ Competitive Sports
  ☐ Water Sports ☐ Fishing
  ☐ Sewing ☐ Driving
  ☐ Boating ☐ Other _____
- Do you currently wear eyeglasses?
  ☐ Yes ☐ No
  If Yes:
  ☐ For distance
  ☐ For near
  ☐ Other _____
- What do you dislike about your current eyeglasses? (weight, style, thickness, glare, etc.)

_____

_____

- Do you currently wear contact lenses?
  ☐ Yes ☐ No
  If No, are you interested in becoming a contact lens wearer? ☐ Yes ☐ No
  If Yes, what type of contacts do you wear?
  ☐ Soft
  ☐ Hard (RGP)
  ☐ Disposable, how often do you replace the lenses? _____
  Brand _____
- What do you dislike about your current contact lenses? (vision, dryness, comfort, etc.)

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