Patient History *We appreciate you taking the time to update our records!* Male/Female/ Marital status: S( ) M( ) D( ) W( )

Date_____Patient Name_____Nickname (if you prefer we call you)_____

Birth Date_____ Phone/s: Home#_____Cell#_____

Do you prefer we call: **Home** ☐ **Cell**☐ Is it okay that we *text message* you for reminders? **Yes** ☐ **No** ☐

Do we have permission to leave you a voice-mail message on your phone? **Yes** ☐ **No** ☐ If yes, on your: **Home** ☐ **Cell**☐ **Both**☐

Address_____City_____ State_____ Zip_____

E-Mail_____ SSN_____ Hobbies_____

Do you have Vision Insurance? **Yes**☐ **No**☐ Name_____

Do you have Major Medical Insurance (health insurance)? **Yes**☐ **No**☐ Is it: **PPO**☐ **HMO**☐
Name_____

Name of your Primary Medical Doctor (first and last)_____ City_____

Occupation [Grade if student]_____ Employer [Or School]_____Part-time☐ Full-time☐

Are you having any problems with your vision?_____

Last eye exam _____Where_____ How did you hear about us? _____

Have you *ever* worn contact lenses? **Yes** ☐ **No** ☐ Have you worn contact lenses *in the past year*? **Yes** ☐ **No** ☐

Are you interested in wearing contact lenses *this year*? **Yes** ☐ **No** ☐ If your answer is ***Yes***, please make sure you have *signed* and *read* the 'Contact Lens Fees' section thoroughly of the 'Office Policies & Disclaimers' handout of your paperwork.

Are you interested in Lasik? **Yes**☐ **No**☐
Are you Pregnant? **Yes**☐ **No**☐ Are you Nursing? **Yes**☐ **No**☐

MEDICAL HISTORY

Do ***you*** and/or any ***family members*** have any of the conditions listed below? [ie: parents, grandparents, self]

CONDITION:	**If yes, please list who:**
Diabetes type **I**	**Yes / No** _____
Diabetes type **II**	**Yes / No** _____
Macular Degeneration	**Yes / No** _____
Glaucoma	**Yes / No** _____
Cataracts	**Yes / No** _____
Blindness	**Yes / No** _____
'Lazy'/Turned eye	**Yes / No** _____
High Cholesterol	**Yes / No** _____
High Blood Pressure	**Yes / No** _____
Thyroid Disease	**Yes / No** _____

Have you had any major surgeries? **Yes** ☐ **No** ☐
If yes, on what organs?
_____

Please list **all medications** you are taking or frequently take:

Medication name:	To treat:
_____	for:_____
_____	for:_____
_____	for:_____
_____	for:_____

Do you have any allergies? **Yes** ☐ **No** ☐ [**ie:** Food products, environmental, drugs] _____

OCULAR HISTORY

Do you wear glasses? **Yes** ☐ **No** ☐**…** If yes, do you wear them to see: Far☐ Near☐ Both☐

How many hours *per day* do you use a computer? Less than 1 hour ☐ 2-4 hours ☐ 5-8 hrs ☐ More than 8 hrs☐

How many computer monitors do you use at a given time? 1 ☐ 2 ☐ 3 ☐ 4 ☐

Do you experience any of the following symptoms?

Dry eyes	**Y** ☐ **N** ☐	Eyes watering / tearing	**Y** ☐ **N** ☐
Floaters	**Y** ☐ **N** ☐	Grittiness (Like sand)	**Y** ☐ **N** ☐
Headaches	**Y** ☐ **N** ☐	Eyes burning / stinging	**Y** ☐ **N** ☐
Eye pain	**Y** ☐ **N** ☐	Distance blur	**Y** ☐ **N** ☐ If yes: With glasses ☐ W/out glasses ☐ With Cl's ☐ W/out Cl's ☐
Eyes redness	**Y** ☐ **N** ☐	Near blur	**Y** ☐ **N** ☐ If yes: With glasses ☐ W/out glasses ☐ With Cl's ☐ W/out Cl's ☐
Eye itching	**Y** ☐ **N** ☐	Other: Please explain:	_____

Does bright light / glare bother you? **Yes** ☐ **No** ☐ Please circle: headlights / taillights / overhead lighting / fluorescent lighting / computer / sun

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