Name: ____________________________ Date of Birth: _______________ Today's Date: ________________
Address: _______________________________ City: ______________________ State: ______ Zip: ___________
Preferred Phone: __________________________(cell / work / home) Email: ____________________________

Do your eyes ever experience:

○ Gritty or sandy sensation?	Never	Slight	Moderate	Severe
○ Pain or soreness?	Never	Slight	Moderate	Severe
○ Fluctuating vision?	Never	Slight	Moderate	Severe
○ Occasional tearing?	Never	Slight	Moderate	Severe
○ Discomfort in windy conditions?	Never	Slight	Moderate	Severe
○ Itching?	Never	Slight	Moderate	Severe

How often do you use artificial tears? Never ________ times per week ________times per day

Do you have...? Diabetes High Blood Pressure High Cholesterol Rheumatoid Arthritis Thyroid Disease
Please list any changes in your medical history: ____

Would you be interested in wearing contact lenses? Already wear contacts YES Maybe NO

Do you have difficulty seeing and/or driving at night? YES NO

Do you have a family history or macular degeneration? YES NO

If you currently wear contact lenses, please rate how comfortable they are: (1 poor, 10 excellent)
At the beginning of the day ___/10 At the end of the day ___/10

Do/have you: (please circle)

Smoke/Use Tobacco?	Never	Formerly	Currently some days	Currently everyday
Use Alcohol?	Never	Formerly	Currently some days	Currently everyday

Please list your current medications (including over-the-counter medications)

____

Please list any current allergies (including allergies to medications)

____

What is your preferred pharmacy? (please include name and address)

____

Would you be interested in obtaining access to your online patient portal? YES NO

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company; not Midwest Eye Associates.

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand the Notice of Privacy Practices and I have been provided an opportunity to review it. If you wish to read the Notice of Privacy Practices, it is listed on our website.

Patient Signature ____ Date ______________________