**Welcome To Our Office**

In order to provide us with a better understanding of your eye care needs, please complete the following history.

**(PLEASE PRINT)**

Name (Last, First, M.I.) Date:

Address: Home Phone:

City/State/Zip: Cell Phone:

Email: Date of Birth:

Age: Sex: Responsible Party: Date of last eye exam: Recommended by?:

Have you ever worn glasses?: How are they used? [ ] Distance [ ] Near [ ]Full Time

Occupation: Employer:

Type of Insurance you have:

**Reason for visiting our office today: (Please check appropriate items)**

\_\_\_ General Check-up \_\_\_ Eyes Water \_\_\_ Want Contact Lenses

(no specific problems) \_\_\_ Glare \_\_\_ Problems with present contact lenses

\_\_\_ Lost or broken glasses \_\_\_ Eyes burn \_\_\_ Others (Please List)

\_\_\_ Want new eyeglasses \_\_\_ Eyes itch

\_\_\_ Blurred distance vision \_\_\_ Eyes feel dry

\_\_\_ Blurred near vision \_\_\_ Eyes feel tired

\_\_\_ Headaches – when do you \_\_\_ Pain in eyes

get them and how often? \_\_\_ See “spots” or “flashes”

Hobbies:

**Contact Lens Information**

Do you wear contacts? \_\_\_ if so, what type? (please check all that apply) [ ] Soft [ ] Hard/Gas Permeable (RGP)

[ ] Daily Wear – how many hours a day? \_\_\_\_\_\_ [ ] Extended Wear – how many days in a row? \_\_\_\_\_\_

[ ] Disposable – how often do you dispose of them? \_\_\_\_\_\_

Brand of Contact Lens you wear: Brand of Contact Lens cleaner used:

**Your General Health and Ocular Health: Past or Present**

\_\_\_ High Blood Pressure \_\_\_ Heart Disease \_\_\_ Cataracts \_\_\_ Stabismus

\_\_\_ Diabetes \_\_\_ Allergies \_\_\_ Glaucoma \_\_\_ Amblyopia

\_\_\_ Tuberculosis \_\_\_ Cancer \_\_\_ Retinal disorders \_\_\_ Eye Injuries

\_\_\_ Arthritis \_\_\_ HIV exposure \_\_\_ Eye Surgery \_\_\_ Others: (indicate)

\_\_\_ Migraines \_\_\_ Respiratory Problems

\_\_\_ Circulatory problems \_\_\_ Multiple sclerosis

Has anyone in your family (blood relatives) had any of the above conditions? Yes \_\_\_\_\_\_ No\_\_\_\_\_\_\_

If so, which relative and what condition(s)? (Please list)

If you are presently taking any medication or birth control pills, please state what medication:

Are you pregnant? \_\_\_\_ Yes \_\_\_\_ No

We strongly recommend Optos photos for all our patients. This takes the place of a dilation with the advantage of photo documentation without the use of eye drops and without side effects (blurred vision and light sensitivity as with dilation). This is not covered under a routine exam and costs $35. **I want an Optos photo today: \_\_\_\_ Yes \_\_\_\_ No**

I certify that the information contained on this form is complete and accurate and that I have been presented with the **Notice of Privacy policy**.

Signature Date