

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** ☐

Floaters **Y** ☐ **N** ☐

Headaches **Y** ☐ **N** ☐

Eye pain **Y** ☐ **N** ☐

Eyes redness **Y** ☐ **N** ☐

Eye itching **Y** ☐ **N** ☐

Eyes watering / tearing **Y** ☐ **N** ☐

Grittiness (Like sand) **Y** ☐ **N** ☐

Eyes burning / stinging **Y** ☐ **N** ☐

Distance blur **Y** ☐ **N** ☐ If yes: With glasses ☐ W/out glasses ☐ With CI's ☐ W/out CI's ☐

Near blur **Y** ☐ **N** ☐ If yes: With glasses ☐ W/out glasses ☐ With CI's ☐ W/out CI's ☐

Other: Please explain: _____

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