Name: _____ **D.O.B:** _____ **Date:** _____ **Patient #** _____

VISION HISTORY: Month/year of your last eye exam? _____ by Dr._____

Glasses: Have you ever worn glasses? ❑ No ❑ Yes ❑ for distance ❑ reading / computer ❑ for both distance & near

What kind of glasses do you wear? ❑ Single Vision ❑ Bifocals ❑ No-Line (progressive) ❑ ***Sports Glasses***

Contacts: Do you currently wear contacts? ❑ No ❑ Yes What type? _____

Do you need to update your contact lens Rx today? _____ (Remember Rx is only good for one year)

Have you had problems wearing contacts, or told you cannot wear them? ❑ No ❑ Yes Describe _____

Are you interested in trying contacts today for the **first** *time?* ❑ No ❑ Yes

If you are a **contact lens wearer**, your needs for visual care are more complex than those of our patients who chooses to wear glasses only. And you will be receiving additional testing and evaluation during your visit with us. We charge one fee for fitting and that includes all follow up visits until YOUR final CL prescription is done, it also includes a *free* 6 month contact lens follow up visit.

HEALTH HISTORY: **Please answer Yes for ALL CONDITIONS *as they apply to you* or family history.**

	Patient	Family		Patient	Family
ADD or ADHD	❑ Yes-Pt	❑ Yes-Family	Neurological Disorder	❑ Yes-Pt	❑ Yes-Family
Allergies	❑ Yes-Pt	❑ Yes-Family	Seizure Disorders	❑ Yes-Pt	❑ Yes-Family
Autism	❑ Yes-Pt	❑ Yes-Family	STD (Sexually Transmit Disease)	❑ Yes-Pt	❑ Yes-Family
Cancer	❑ Yes-Pt	❑ Yes-Family	Thyroid	❑ Yes-Pt	❑ Yes-Family
Cerebral Palsy	❑ Yes-Pt	❑ Yes-Family	Blindness	❑ Yes-Pt	❑ Yes-Family
Developmental Delays	❑ Yes-Pt	❑ Yes-Family	Cataracts	❑ Yes-Pt	❑ Yes-Family
Diabetes - **Type 1**	❑ Yes-Pt	❑ Yes-Family	Color "blind"	❑ Yes-Pt	❑ Yes-Family
Diabetes - **Type 2** (Adult onset)	❑ Yes-Pt	❑ Yes-Family	Dry Eyes	❑ Yes-Pt	❑ Yes-Family
Drug sensitive	❑ Yes-Pt	❑ Yes-Family	Eye Turn/Strabismus	❑ Yes-Pt	❑ Yes-Family
Dyslexia	❑ Yes-Pt	❑ Yes-Family	Eyestrain	❑ Yes-Pt	❑ Yes-Family
Elevated Cholesterol	❑ Yes-Pt	❑ Yes-Family	Flashing lights	❑ Yes-Pt	❑ Yes-Family
Gastrointestinal Disease	❑ Yes-Pt	❑ Yes-Family	Floaters/Spots	❑ Yes-Pt	❑ Yes-Family
Glandular Disorder	❑ Yes-Pt	❑ Yes-Family	Glaucoma	❑ Yes-Pt	❑ Yes-Family
Head trauma	❑ Yes-Pt	❑ Yes-Family	Lazy eye /Amblyopia	❑ Yes-Pt	❑ Yes-Family
Headache/Migraine	❑ Yes-Pt	❑ Yes-Family	Light sensitive	❑ Yes-Pt	❑ Yes-Family
Heart problem	❑ Yes-Pt	❑ Yes-Family	Macular degeneration ❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
High blood Pressure	❑ Yes-Pt	❑ Yes-Family	Retinal detachment ❑ No-Pt	❑ Yes-Pt	❑ Yes-Family
Learning Disabilities	❑ Yes-Pt	❑ Yes-Family	Eye surgery or injury _____		
Muscular Disorder	❑ Yes-Pt	❑ Yes-Family	Other _____		

PRIMARY OR FAMILY DOCTOR:

Primary Doctor Information ❑ No ❑ Yes Name/# _____ City: _____

Date of your last physical _____ **Are you taking any medications regularly? ❑ Yes ❑ No**

Please list your medications and what conditions they are for:

1 _____ for _____

2 _____ for _____

3 _____ for _____

4 _____ for _____

Please rate your general state of health? *(Circle one)* **Excellent** **Good** **Fair** **Poor**

Please fill in BOTH **SIDES of this form as completely as possible.**

OCCUPATION: **What kind of work do you do?** _____

What activities do you do at work: (Circle all that apply) driving computers accounting
Writing/editing monitor equipment other: _____

Do you use a computer on your job or at home? ..... ❑ Yes ❑ No # hours daily _____

When on the computer, do your eyes get ..... ❑ red ❑ dry ❑ ache ❑ sore

Do you feel pain or discomfort in your.....❑ neck ❑ back ❑ shoulders?

Do letters ever seem to "swim"? ..... ❑ Yes ❑ No Does office lighting bother you? ❑ Yes ❑ No

Do reflections and glare bother you?..... ❑ Yes ❑ No Is it hard to proofread or find errors? ❑ Yes ❑ No

PAIN OR DISCOMFORT: **Do you experience ANY of the following? (*Check ALL that apply*)**

❑ Headaches ❑ Sensitivity to light? ❑ Stationary objects seem to be moving?

❑ Any pain? **Where** _____ **When** _____

❑ Eyestrain ❑ Letters blur as you read ❑ Occasionally see double ❑ Any blind spots

❑ Eyes red or watery ❑ Eyes dry ❑ Pulling sensation near eyes

❑ Get sleepy or trouble falling asleep ❑ Lose your place often

❑ Avoid certain tasks **What** _____ **When** _____

❑ Takes more and more effort to see clearly as the day wears on?

❑ Avoid reading after work, but read on weekends? How long can you read? _____

❑ "Hunch" closer to your work as the day wears on?

❑ Do street signs seem to blur as you drive home from work? ❑ Yes ❑ No

❑ Is it ever difficult to bring print or objects to clear focus? **When**_____

❑ **NONE OF THE ABOVE**

❑

RECREATION AND LEISURE*:* **What recreational activities do you enjoy? (*Circle ALL that apply)***

Read racquetball soccer tennis golf baseball basketball swim camp auto repair

Sew play cards flying Gaming TV or hand held musical instrument Dance other _____

Is viewing TV ever uncomfortable? Please describe: _____

Do you recline while viewing? ❑ Yes ❑ No Do wear your glasses to watch TV? ❑ Yes ❑ No

Do you often play video games? ❑ Yes ❑ No How often: 1-2 hours 3-6 hours more

EYEWEAR*:* **What are you doing to protect your eyes . . .?**

from UV exposure? _____

while playing sports? _____

Do your glasses have an anti-reflective/anti-glare/anti-scratch/ anti-harmful Blue Light & UV Rays such as **CRIZAL or BluTech*?*** ❑ Yes ❑ No

Are you interested in lenses that "**TRANSITION**" **or darken in sunlight when outside?** ❑ Yes ❑ No

Signed  _____ **Date →** _____

If not the patient, PRINT YOUR NAME: _____ Relationship to patient: _____

Modified 10/17/2015

THANK YOU VERY MUCH FOR YOUR TIME AND EFFORT IN FILLING OUT OUR FORMS.