

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**.

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

PRIMARY OR FAMILY DOCTOR

Name & number of your Primary Doctor? 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 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 LEISUREWhat recreational activities do you enjoy? (*Circle ALL that apply*)

Read racquetball soccer tennis golf baseball basketball swim camp
 Sew play cards flying video games musical instrument 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? _____

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

Do your glasses have an anti-reflective/anti-glare/anti-scratch lens such as **CRIZAL**? Yes No

Signed (X) _____ Date → _____

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

Modified 3/17/2015

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