



PATIENT INFORMATION

EXAM DATE: / /

LAST NAME _____ FIRST NAME _____ M F BIRTH DATE / /

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

E-MAIL ADDRESS _____

EMPLOYER _____ OCCUPATION _____

SS# _____

OCULAR AND MEDICAL HISTORY

WHAT IS THE PRIMARY REASON FOR TODAY'S EXAM? _____

AGE OF PRESENT GLASSES _____ AGE OF SUNGLASSES _____ DATE OF LAST EYE EXAM _____ FROM DR _____

DO YOU OR ANYONE IN YOUR FAMILY HAVE THE FOLLOWING CONDITIONS?

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE		YES	NO
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU SEE DOUBLE?	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CATARACTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT HEADACHES?	<input type="checkbox"/>	<input type="checkbox"/>
THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RETINAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BRIGHT LIGHTS BOTHER YOU?	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYE SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYE INJURY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYES BEEN DILATED?	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	YEAR? _____		

PRIMARY CARE DR _____ AT _____

PLEASE EXPLAIN ANY OTHER FINDINGS: _____

ARE YOU TAKING ANY MEDICATION, PRESCRIPTION OR OVER THE COUNTER? PLEASE LIST _____

ARE YOU TAKING ANY EYE DROPS, PRESCRIPTION OR OVER THE COUNTER? PLEASE LIST _____

DO YOU HAVE ANY ALLERGIES, MEDICATION OR OTHER? IF YES, PLEASE EXPLAIN _____

DO YOU WEAR CONTACT LENSES NOW? YES NO IF YES, WHAT TYPE? _____HAVE YOU WORN CONTACT LENSES? YES NO IF YES, WHAT TYPE? _____ARE YOU INTERESTED IN NEW CONTACT LENSES? YES NO IF YES, WHAT TYPE? _____

SPECIAL TASKS INFORMATION

DO YOU PARTICIPATE IN ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

- NIGHT DRIVING EXTENDED READING FINE, DETAILED WORK (SEWING / NEEDLEPOINT) HOME REPAIR / YARD WORK
- DANGEROUS WORK ENVIRONMENT (SAFETY Rx) COMPUTER USE - HOW MANY HOURS? _____
- PLAY A MUSICAL INSTRUMENT - WHICH ONE(S)? _____

SUN AND SPORT INFORMATION

HOW MANY HOURS A DAY ARE YOU OUTSIDE IN THE SUN? _____

DO YOU WEAR SUNGLASSES WHILE OUTSIDE? YES NO

IN WHAT ACTIVITIES DO YOU PARTICIPATE? (CHECK ALL THAT APPLY)

- GOLF RACQUET SPORTS FISHING / BOATING / SAILING
- BASEBALL / SOFTBALL FOOTBALL / BASKETBALL SKIING / SNOW BOARDING RUNNING / ROLLERBLADING / BIKING
- OUTSIDE WORK (OCCUPATION) _____ OTHER (PLEASE LIST) _____