Patient Information

PATIENT NAME _____ **DATE OF BIRTH** ____/____/_____

PHONE NUMBER (_____) _____ - _____ **EMAIL** _____

PLEASE CONTACT US VIA: ☐ PHONE ☐ TEXT ☐ EMAIL

HOW DID YOU HEAR ABOUT US? ○ CURRENT PATIENT ○ REFERRAL ○ INTERNET SEARCH ○ DRIVE BY ○ OTHER

EYE/VISUAL HISTORY

How long ago was your last eye exam? ○ <1 yr ○ 1 yr ○ 2-3 yrs ○ 5-10 yrs ○ 10+ yrs

Where? _____

Are you happy with your current glasses prescription? ○ NO ○ YES

Are you interested in seeing without glasses? ○ NO ○ YES

Are you interested in wearing contact lenses? ○ NO ○ YES

Do you currently wear contact lenses> ○ NO ○ YES

If *YES, h*ow long do you go before replacing your contact lenses?

○ 1 day ○ 1 week ○ 2 weeks ○ 1 month ○ 6 weeks or more

Do your eyes feel dry in your contact lenses? ○ NO ○ YES

If *YES,* how quickly? ○ immediately ○ within a few hours ○ by midday ○ at end of day

How much time do you spend on a computer per day? _____

Do you have headaches/eyestrain during or after computer use? ○ NO ○ YES

Do you experience dry eyes or watering eyes? ○ NO ○ YES

Are you interested in refractive surgery/LASIK? ○ NO ○ YES

Have you had any eye surgeries? ○ NO ○ YES: _____

Have you had any eye injuries? ○ NO ○ YES: _____

Please indicate if you / a family member has been diagnosed with any of the following conditions:

Glaucoma	○ SELF	○ FAMILY:	_____
Macular Degeneration	○ SELF	○ FAMILY:	_____
Cataracts	○ SELF	○ FAMILY:	_____
Dry Eye	○ SELF	○ FAMILY:	_____
Diabetic Retinopathy	○ SELF	○ FAMILY:	_____
Retinal Detachment	○ SELF	○ FAMILY:	_____
Strabismus (Eye Turn)	○ SELF	○ FAMILY:	_____
Amblyopia (Lazy Eye)	○ SELF	○ FAMILY:	_____
Blindness/ Vision Loss	○ SELF	○ FAMILY:	_____
Stroke	○ SELF	○ FAMILY:	_____
Migraine/ Headache	○ SELF	○ FAMILY:	_____
Other: _____			

GENERAL MEDICAL HISTORY

Primary Care Physician: _____ Phone: (_____)_____-_____
Date of Last Evaluation: ____/____/_____

Please indicate any current or past problems in the following health systems and medications you are taking as treatment

Gastrointestinal	○ NO	○ YES: _____	Med(s): _____
Ear/Nose/Throat	○ NO	○ YES: _____	Med(s): _____
Respiratory	○ NO	○ YES: _____	Med(s): _____
Musculoskeletal	○ NO	○ YES: _____	Med(s): _____
Cardiovascular	○ NO	○ YES: _____	Med(s): _____
Integumentary (Skin)	○ NO	○ YES: _____	Med(s): _____
Endocrine (Glands)	○ NO	○ YES: _____	Med(s): _____
Neurological	○ NO	○ YES: _____	Med(s): _____
Genitourinary	○ NO	○ YES: _____	Med(s): _____
Blood/Lymph	○ NO	○ YES: _____	Med(s): _____
Mental Health	○ NO	○ YES: _____	Med(s): _____
Allergies/Immunity	○ NO	○ YES: _____	Med(s): _____

Please list any medication allergies: _____
Please list any other allergies: _____
Please list any additional health history/surgeries:

_____
_____
_____

SOCIAL HISTORY

Occupation: _____
Main Visual Activities: _____
Do you smoke? ○ NO ○ YES: _____
Do you drink alcohol? ○ NO ○ YES: _____
Do you use other substances? ○ NO ○ YES: _____

_____ _____
Signature Date

STUDENTS/ PARENTS OF STUDENTS, PLEASE COMPLETE:

In order to assist your doctor in evaluating the visual skills needed in the learning environment, please mark any of the below that apply to you/ your child.

Curriculum: ○ Regular Classroom ○ Honors/AP Curriculum ○ Special Education ○ IEP/504 Plan ○ Tutoring

School Performance: ○ Average ○ Above Average ○ Below Average ○ Smart in everything but school
○ Excels in all areas except reading ○ Excels in all areas except math ○ Repeated grade

Homework: ○ Completes without problems ○ Short Attention Span ○ Takes longer than it should

Reading: ○ Enjoys reading ○ Avoids reading ○ Prefers to be read to ○ Poor comprehension ○ Slow reader

Sports: ○ Good athlete ○ Personally trained ○ Reduced sports performance ○ Avoids sports

Additional Therapy: ○ Occupational ○ Speech ○ Physical ○ Psychological ○ Other: _____

If there is anything else about your child's vision that you would like to share with the doctor privately, please mark here: ☐