

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 Eyes watering / tearing Y N

Floaters Y N Grittiness (Like sand) Y N

Headaches Y N Eyes burning / stinging Y N

Eye pain Y N Distance blur Y N If yes: With glasses W/out glasses With CI's W/out CI's

Eyes redness Y N Near blur Y N If yes: With glasses W/out glasses With CI's W/out CI's

Eye itching Y N Other: Please explain: _____

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

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