Patient Status: □New □Existing Today's Date______________________
Patient's Name (Title, First Last): ____________________________________________________________________________________________
Home Address: ______________________________________________ City: ________________________State: _____________Zip: ____________
Date of Birth: _____________________ Age: ______________ M/F SSN ______ - ______ - ______
Cell Phone: ______________________________ Home Phone: ___________________________Work Phone: ____________________________
E-mail Address: ______________________________________________________________ □ No email
What is your Occupation? ____________________________________________________ Race/Ethnicity _______________________________
Primary Care Physician: ______________________________________________________ Date of last physical: ___________________________
Address: __________________________________________________ Phone: ___________________________ Fax: __________________________

## Patient Ocular and Medical History

**Date of last eye examination:** __________________________

**What is the reason for your examination today?** _______________________________________________________________________________

**Are you currently experiencing:**
□Spots/Floaters □Flashing Lights □Eye Pain/Ache □Red Eye □Sandy Feeling □Dry/Itchy Eyes □Double Vision
□Distance Blur □Near Blur □Focus Difficulty □Intense Light Sensitivity □Trouble Driving at Night

**Have you ever had:** □Eye Surgery □Vision Training □Eye Patching □ Eye Injury □Lazy Eye □Head Trauma

**Do you currently wear Contact Lenses?** □Yes □No
If no, would you be interested in Contact Lenses □Yes □No
If yes: What type do you wear? □Soft □Gas Permeable
How often do you replace each pair? ____________________ How many hours per day do you wear contacts? ____________________
What solution do you use to clean the lenses? ________________ How many hours have you been wearing them today? ___________
Do you ever sleep with your lenses on? □No □Yes, how often? ________________________

**Do you currently wear Glasses?** □Yes □No
If yes: Do you wear glasses for: □Distance □Reading □Both

**Have you ever considered Laser Vision Correction (Lasik)?** □Yes □No

**Do you have a child under age 10 that you would like our Pediatric Optometrist to examine?** □Yes □No

**Do you presently work with a computer?** □Yes □No If yes, how many hours per day? _________________
Are you experiencing any of the following: □Eye Strain □Eye Irritation □Eye Dryness □Backaches □Neck Strain □Headaches

**Do you participate in sports, recreational or outdoor activities (especially around snow or water)?** □Yes □No
If yes, which? ____________________________________________________________________________________________________

**Do you have any of the following (past and present):**
□Cataract □Macular Degeneration □Glaucoma □Diabetes □High Blood Pressure □Cholesterol □Head Injury □Heart Disease
□Epilepsy □Thyroid problems □Neurological Disease □Cancer □Other (please specify): _______________________________________

**Are you taking any medications or pills (including birth control)?** □Yes □No
If yes, please list and explain the purpose: ____________________________________________________________________________

**Are you allergic to any medications?** □Yes □No If yes, please list and explain: ___________________________________________________

**Do you smoke?** □Yes, _____ cigarettes per day □No, never smoker □No, former smoker

**Do you drink alcohol?** □Yes, _____ drinks per day □No

**Are you dependent on recreational drugs?** □Yes □No If yes, which drug(s)? ________________________________________

**Have you been exposed to or infected with:** □Gonorrhea □Hepatitis □HIV/AIDS □Syphilis □None □Other (please specify):_______________

## Family Ocular and Medical History

**Have any of your relatives, living or deceased, had any of the following conditions:**
□Blindness □Cataract □Crossed Eyes □Glaucoma □Macular Degeneration □Retinal Detachment/Disease
□Arthritis □Cancer □Diabetes □Heart Disease □Thyroid Disease □High Blood Pressure □Kidney Disease □Lupus
□Other (please specify): ____________________________________________________________________________________________