

**PATIENT INFO & HISTORY**

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Name: \_\_\_\_\_ Home Tel: \_\_\_\_\_  
 Address: \_\_\_\_\_ Work Tel: \_\_\_\_\_  
 City, State Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

**Vision Insurance Provider:** → \_\_\_\_\_

**I, the undersigned, acknowledge that it is the policy of this office that all payments are made at each visit and that I am responsible for payment/co-payment of services for the patient above.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Reason for visit (Please check all that apply)

- |                                  |                              |
|----------------------------------|------------------------------|
| _____ Routine check-up           | _____ Broken or lost glasses |
| _____ Blurred vision at distance | _____ Referral               |
| _____ Blurred vision at near     | _____ Contact lens fitting   |
| _____ Headaches or eye fatigue   | _____ Other                  |

Please check any of the following that applies to yourself or any members of your immediate family.

	<b>SELF</b>	<b>FAMILY</b>		<b>SELF</b>	<b>FAMILY</b>
Diabetes	_____	_____	Glaucoma	_____	_____
High Blood Pressure	_____	_____	Cataracts	_____	_____
Respiratory Problems	_____	_____	Eye/Head Injury	_____	_____
Kidney Disease	_____	_____	Blindness	_____	_____
Thyroid Disease	_____	_____	Flashes of Light	_____	_____
Arthritis	_____	_____	Spots in Vision	_____	_____
Cancer	_____	_____	Eye Injury	_____	_____
Headaches	_____	_____	Lazy/Turned Eye	_____	_____
Double Vision	_____	_____	Burning Eyes	_____	_____
Temporary Loss of Vision	_____	_____	Red Eyes	_____	_____
Itchy Eye	_____	_____	Dry Eyes	_____	_____
Retinal Detachment	_____	_____	Other (Explain)	_____	_____
CL Complications	_____	_____			

Please list any current medications you are taking: \_\_\_\_\_

Please list any known allergies (medical and/or environmental): \_\_\_\_\_

Do you wear glasses (please circle one)? Yes or No How old are they? \_\_\_\_\_ Yrs.  
 Circle what type: Single Vision Lined Bifocal Progressive (no-line) Bifocal Reading Glasses

Date of last exam: \_\_\_\_\_

Do you wear contact lenses? \_\_\_\_\_

Date of last contact lens exam: \_\_\_\_\_

Please circle type of contact lenses you have:  
Soft Daily Wear Soft Extended Wear RGP Disposable List Brand: \_\_\_\_\_

Solution used to disinfect contact lenses: \_\_\_\_\_

Please answer "Yes" or "No" to the following:

	<b>YES</b>	<b>NO</b>
Do you work on a computer?	_____	_____
Do you have difficulty driving at night?	_____	_____
Do you have trouble with glare?	_____	_____
Do you work under fluorescent lighting?	_____	_____
Would you like to try contact lenses?	_____	_____
Did you know that a child should have an eye exam starting at age 3?	_____	_____