# Welcome to our Office

Name________________________________________ Today's Date____________ Last Eye Exam__________
Nickname____________________________________
Street______________________________________
City ______________________State ____ Zip ________
Date of Birth_____________ Age__________ Sex: M F
Social Security Number ___________________________
Home Phone __________________________________
Work Phone __________________________________
Cell Phone __________________________________
E-mail Address _______________________________
Spouse(or Parent's)Name_________________________
Children's Names and Ages_______________________
Employer/School _______________________________
Occupation/Grade_______________________________
Emergency Contact _____________________________
_____________________________________________
What is the purpose of today's visit? ________________
_____________________________________________

**Do You…**

| | | |
|---|---|---|
| Currently wear glasses? | Y | N |
| Currently wear contacts? | Y | N |
| If so, what kind_________________ | | |
| Solutions used__________________ | | |
| If not, are you interested in contact lenses? | Y | N |
| Have interest in Laser Vision Correction? | Y | N |
| Work on computer for long periods of time? | Y | N |
| Have problems with glare? | Y | N |
| Have sunglasses? | Y | N |
| Spend time outdoors? | Y | N |

**Personal and Family History** (Parent, grandparent, sibling, children) Please check any of the following for which you or a family member has a history and list relationship below.

| | Y | N | | Y | N |
|---|---|---|---|---|---|
| Blindness | □ | □ | Thyroid | □ | □ |
| Retinal Detachment | □ | □ | Arthritis | □ | □ |
| Glaucoma | □ | □ | Lupus | □ | □ |
| Cataracts | □ | □ | Cancer | □ | □ |
| Eye Disease | □ | □ | Diabetes | □ | □ |
| Strabismus | □ | □ | Heart Disease | □ | □ |
| Macular Degeneration | □ | □ | Kidney | □ | □ |
| Dyslexia | □ | □ | Nerves | □ | □ |
| Attention Deficit Disorder | Y□ | N□ | High Blood Pressure | Y□ | N□ |

**Do you experience…**

| | |
|---|---|
| □ Redness | □ Glare or reflection |
| □ Spots/Floaters | □ Tearing |
| □ Flashes of light | □ Dryness |
| □ Double vision | □ Burning |
| □ Blurry distance vision | □ Eye Strain |
| □ Blurry near vision | □ Soreness |
| □ Sudden loss of vision | □ Sensitivity to light |
| □ Uncomfortable glasses | □ Itching |
| □ Uncomfortable contacts | □ Headaches |

**Current Medications (Rx or Over the counter)**

1.
2.
3.
4.
5.

**Allergies to Medications?** Y N

If so, please list:

1.
2.
3.

**How did you choose our office for your eye care?**

□ Family/Friend Referral ____________________________________________

□ Professional Referral ____________________________________________

□ Insurance Provider List__________________________ □ Advertisement In_____________________