WELCOME TO OUR OFFICE

PATIENT INFORMATION
PLEASE PRINT CLEARLY

LAST NAME________________________________FIRST NAME____________________________MI____ M/F BIRTHDATE__________AGE________

HOME ADDRESS____CITY_____________________________STATE______ZIP__________

HOME PH ________________________________WORK PH________________________________CELL PH__________________________________

EMPLOYER__________________________________OCCUPATION__________________________EMAIL___________________________________

REFERRED BY_________________________EMERGENCY CONTACT NAME_______________________________PHONE_________________________

MEDICAL HISTORY

REASON FOR TODAY'S VISIT: _____ROUTINE EXAM_____CONTACT LENSES_____VISION PROBLEM_____OTHER:_______________

____

AGE OF PRESENT GLASSES______________LAST EYE EXAM DATE_________________FROM DR: _______________________

LAST TIME YOUR EYES WERE DILATED______________________ or NEVER (circle)

PLEASE INDICATE IF ***YOU*** HAVE HAD OR CURRENTLY HAVE ANY CONDITIONS LISTED BELOW:

___DRY EYE	___DOUBLE VISION	___GLAUCOMA	___ HEART CONDITION	___ASTHMA
___RED EYE	___FLASHES OF LIGHT	___RETINAL DISEASE	___ THYROID CONDITION	___OTHER
___ITCHY EYE	___FLOATERS	___CATARACTS	___ HIV/AIDS	(LIST BELOW)
___EYE INJURY	___HEADACHES	___DIABETES	___ARTHRITIS	
___EYE SURGERY	___LAZY/TURNED EYE	___HIGH BLOOD PRESSURE	___CANCER	

____

IS THERE A FAMILY HISTORY OF: ___DIABETES___HIGH BLOOD PRESSURE___GLAUCOMA___RETINAL DISEASE___OTHER:_______
WHO____

LIST OF MEDICATIONS (INCLUDING NON-PRESCRIPTION) ____

____

ALLERGIES TO MEDICATIONS____

DO YOU WORK WITH A COMPUTER? _________HOURS PER DAY__________HOBBIES/ SPORTS: ___________________________

DO YOU SMOKE? ___________________ARE YOU PREGNANT OR NURSING (IF APPLICABLE)? ______________________________

ARE YOU INTERESTED IN NEW CONTACT LENSES OR IN RENEWING A CONTACT LENS PRESCRIPTION TODAY? YES NO

ARE YOU INTERESTED IN LASIK EYE SURGERY? ____

CONTACT LENS HISTORY

BRAND/POWER OF CONTACT LENSES YOU WEAR____

AGE OF PRESENT CONTACTS_____________REPLACEMENT FREQUENCY_______________LAST WORN ROUTINELY_____________

HAVE YOU EVER WORN ANY OF THESE SPECIALTY LENSES? TORIC MONOVISION BIFOCAL RGP

DO YOU SLEEP WITH YOUR CONTACT LENSES ON? YES NO ________DAYS CONTINUOUSLY

WHAT SOLUTION DO YOU USE? OPTIFREE RENU COMPLETE AQUIFY BIOTRUE CLEARCARE BOSTON OTHER

SEE OTHER SIDE →

WE ARE DEDICATED TO OFFERING YOU THE BEST EYE CARE POSSIBLE USING THE BEST TOOLS BECAUSE NOTHING IS MORE PRECIOUS THAN YOUR EYESIGHT!