Vision Care

To help us better assist you today, please provide us with the following updated information.

Date_____

Name_____ **Address**_____

Home Phone_____
Work_____ **City/State**_____**Zip Code**_____
Cell _____

Preferred contact number:
- ❑ Home
- ❑ Work
- ❑ Cell

Email Address_____

What is your Occupation?_____

Are you interested in purchasing glasses or prescription sunglasses today?
- ❑ Yes
- ❑ No

Are you experiencing any of the following?
- ❑ Headaches
- ❑ Sensitivity to light
- ❑ Poor near vision
- ❑ Poor distance vision
- ❑ Eye irritation
- ❑ Glare (circle all that apply)
  - Computer monitor
  - Night driving
  - Florescent lighting
  - Cell phone
  - Television

Please rate your eye strain/fatigue on a scale of 1-10, 10 being the worst.

_____

To further assist your needs, please circle the appropriate answer:

❑ Are you on a computer more than 4 hours per day?	**Y**	**N**
❑ Do you use your near vision more than 4 hours a day? (Texting, reading, etc.)	**Y**	**N**
❑ Do you participate in any water sports? (Fishing, skiing, etc.)	**Y**	**N**
❑ Do any of your recreational hobbies include flying, golfing, hiking, or biking?	**Y**	**N**

Please list any additional comments or changes in medical history, including new medications:

_____

_____

Visual Field Test:

A new computerized instrument now enables us to check for areas of loss of sight in the central (straight ahead) and peripheral (side view) areas. **It can detect early signs of glaucoma, retinal problems, neurological diseases, macular disorders and headache related illnesses.**

We strongly recommend our patients receive this test in addition to their comprehensive visual analysis. The fee for the test is $45.00.

Would you like to receive this test?
- ❑ Yes
- ❑ No