Sun Valley Eye Care, Inc.

Patient Name: _____ **Date of Birth**_____

REASON FOR VISITING OUR OFFICE (please check all that apply):

Annual (Well-Vision) Exam

- ☐ Contact Lens Exam (*please complete our survey form*)
- ☐ Blurred Near and/or Distance Vision
- ☐ Trouble Seeing at Night
- ☐ Computer Eye Strain
- ☐ Lost or Broken Glasses
- ☐ Lenses are Scratched
- ☐ Want New Glasses
- ☐ Want Thinner/Lighter Glasses

The Below Symptoms May Require a Medical Exam

- ☐ Headaches
- ☐ Eyes: ☐ burn ☐ itch ☐ water ☐ feel tired ☐ feel dry
- ☐ Flashes of Light
- ☐ Floaters (black specks & spots)
- ☐ Foreign Body (something in the eye)
- ☐ Other (please explain):

_____

_____

When was your last eye exam (month/year)? _____ or please approximate below:
○ Less than 1 Year ○ 1-2 Years ○ 3+ Years ○ Unknown ○ Never

Where was your last eye exam (office name/doctor name)? _____ or please approximate below:
○ School ○ MVD ○ Physician's Office ○ Mall ○ Nationwide Vision ○ Not Sure

MEDICAL CONDITIONS: Please check **("S" for self)** or **("F" for family)** or if none apply, please mark **None**

Ocular History: None ☐ Medical History: None ☐

	S	F		S	F		S	F		S	F
Glaucoma	☐	☐	Cataracts	☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐
Macular Degeneration	☐	☐	Blindness	☐	☐	Heart problems	☐	☐	High Cholesterol	☐	☐
Retinal Detachment	☐	☐	Eye Infections/Ulcers	☐	☐	Thyroid problems	☐	☐	Allergies	☐	☐
Retinal Tear/Hole	☐	☐	Eye Surgery/Injury	☐	☐	Cancer/Tumors	☐	☐	Sinus problems	☐	☐
Amblyopia (lazy eye)	☐	☐	Flashes/Floaters	☐	☐	Arthritis	☐	☐	Headaches	☐	☐
Strabismus (eye turn)	☐	☐		☐	☐	Lupus	☐	☐	Pregnant	☐	☐

Do you smoke? ○ Yes ○ No If yes, please indicate frequency _____

Please provide primary care physician info including phone number, date of last visit & any other pertinent health info.

_____

Please list all the medications you are currently taking or write NONE

_____

_____

_____

Do you have any allergies to medications? (Please list all that apply) or write NONE

_____

Do you have/ have you had any injuries, major surgeries, illnesses, and/or diseases? Please describe below:

_____

_____

_____

I certify that the medical information provided is as current and accurate as possible.

Patient or Guardian Signature: _____ Date _____

Guardian Printed Name: _____