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)? _____

Where was your last eye exam (office name/doctor name)? _____

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

Ocular History: None ☐

S	F	
☐	☐	Glaucoma
☐	☐	Macular Degeneration
☐	☐	Retinal Detachment
☐	☐	Retinal Tear/Hole
☐	☐	Amblyopia (lazy eye)
☐	☐	Strabismus (eye turn)
☐	☐	Cataracts
☐	☐	Blindness
☐		Eye Infections/Ulcers
☐		Eye Surgery/Injury
☐		Flashes/Floaters

Medical History: None ☐

S	F	
☐	☐	High Blood Pressure
☐	☐	Heart problems
☐	☐	Thyroid problems
☐	☐	Cancer/Tumors
☐	☐	Arthritis
☐	☐	Lupus
☐	☐	Diabetes
☐	☐	High Cholesterol
☐		Allergies
☐		Sinus problems
☐		Headaches
☐		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 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: _____