

Patient Name (Mr/ Mrs/ Ms/ Dr) _____
Birth date ___/___/___ SSN _____
Address _____
City _____ State _____ Zipcode _____
Phone (home) _____ (work) _____ (mobile) _____
 Okay to leave voice message Okay to text Okay to email
Email address _____

Medical Insurer _____
Pharmacy name & cross streets _____
Emergency Contact & relationship _____ Contact Number _____

Occupation & Employer _____
How did you hear about us _____

Top concern that you want your doctor to address at today's visit:

Do you currently wear glasses? No Yes, How old are your present pairs? _____

When do you wear your glasses? _____

Do you have prescription sunglasses? No Yes, How old are your present pairs? _____

Do you use any eye drops? No Yes, type/frequency: _____

I am a current contact lens wearer and I want to be evaluated for lenses today

Current lenses are comfortable? Yes No, explain: _____
#days per week of lens wear, on average? _____ #hours per day of wear, on average? _____
#nights slept in lenses per week? _____ How old is current pair? _____
How often do you replace your lenses? why? _____
Cleaning solutions used? _____

I am interested in contact lenses for the first time

CONTACT LENS WEARERS: I understand that contact lenses are a medical device regulated by the FDA. Contacts have a limited and controlled life-span. Like any medical device, proper care is necessary. I understand the necessity of follow-up care to monitor my health. I understand that the use of this medical device presents risk of possible infection and other complications. I understand that contact lenses do not take the place of glasses; they are an adjunct to glasses.

I have read the above and I accept the responsibility for wearing contact lenses

By signing below, I agree that the above information is true/ accurate and constitutes a "signature on file" for your insurance company. I also certify that I have been notified about dilation and accept the consequences of refusal. I have been informed of Privacy Policies for protected health information. Office policy is payment at the time of service. We can provide you with forms for you to submit claims to your insurance company.

Signature _____ **Date** _____
Parent/ Guardian if patient under 18 years old

Current Medical Doctor _____ **Last Medical Exam** _____
 Prior Eye Doctor _____ Last Vision Exam _____

Do you have allergies to medications? No Yes, explain: _____

List ALL medications you take (including contraceptives, aspirin, over-the-counter medications, supplements and home remedies):

List all your eye injuries, eye treatments and eye surgeries (including LASIK and other refractive procedures): _____

Do you get chiropractic adjustments? No Yes Date of last neck adjustment: _____

Have you had Cancer? No Yes, type/ when: _____

Do you smoke cigarettes? No, when did you quit? _____ Yes, #packs/week: _____

Do you vape? No Yes, amount/how long: _____

Do you drink alcohol? No Yes, # drinks per week: _____

Do you use medical marijuana? No Yes, amount/frequency: _____

When did you last use marijuana in any form? _____

Do you use recreational drugs? No Yes, type/how long: _____

Have you ever been exposed to or infected with: HIV Hepatitis Syphilis Gonorrhea Zika
 Lyme Disease West Nile Virus Valley Fever Herpes Cold Sores No, I have not

Do you CURRENTLY have, or had IN PAST, or does a FAMILY member have any of the following:

	CURRENT	PAST		CURRENT	PAST
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>		Migraines/ Headaches	<input type="checkbox"/>
Halos/ Glare	<input type="checkbox"/>	<input type="checkbox"/>		Seizures	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>		Allergies/Hayfever	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>		Sinus Congestion	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>		Dry throat/ mouth	<input type="checkbox"/>
Discharge or mucus	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>
Excess Tearing/ Watering	<input type="checkbox"/>	<input type="checkbox"/>		Emphysema	<input type="checkbox"/>
Sandy/ Gritty Eyes	<input type="checkbox"/>	<input type="checkbox"/>		Chronic Bronchitis	<input type="checkbox"/>
Itchy Eyes	<input type="checkbox"/>	<input type="checkbox"/>		Sleep Apnea	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>		Heart Disease	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>		Vascular Disease	<input type="checkbox"/>
Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>		High Cholesterol	<input type="checkbox"/>
Recent onset Floaters	<input type="checkbox"/>	<input type="checkbox"/>		Stroke/ Brain Injury	<input type="checkbox"/>
Lid Bumps	<input type="checkbox"/>	<input type="checkbox"/>		GI Disease	<input type="checkbox"/>
				Kidney/ Bladder	<input type="checkbox"/>
				Liver Disease	<input type="checkbox"/>
				Arthritis	<input type="checkbox"/>
				Lupus	<input type="checkbox"/>
				Diabetes, Insulin	<input type="checkbox"/>
				Diabetes, Non-Insulin	<input type="checkbox"/>
				Hyper/Hypo Thyroid	<input type="checkbox"/>
				Autoimmune Disease	<input type="checkbox"/>
				Anemia	<input type="checkbox"/>
				Hormonal changes	<input type="checkbox"/>
				Bleeding/ Clotting	<input type="checkbox"/>

Other Medical Concerns or Diagnosis: _____

Are you pregnant? No Yes Nursing? No Yes Trying to get pregnant? No Yes