

**PLEASE FILL OUT AS COMPLETE AS POSSIBLE. THANK YOU!!**

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		<b>PERSONAL INFORMATION</b>		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
Patient's last name:		Patient's first name:		Middle Initial:	Birthdate:
Address:		City		State	Zip
Home Phone #		Business or Cell Phone #		Employer/Name of School	Occupation/Student's Grade Level
Name of Parent or Spouse			e-mail address		Driver's License #      State
Name of Vision Insurance Company		S.S.# (required if using Insurance)		Have we seen other members of your family? <input type="checkbox"/> NO <input type="checkbox"/> YES	
				WHO?	

**MEDICAL & VISUAL HISTORY**

<b>Reason for Today's Visit:</b>	<input type="checkbox"/> Poor Distance Vision	Date of Last Eye Exam:	Location of last eye Exam:
	<input type="checkbox"/> Poor Near Vision		

List Any medical conditions you are being treated for and for how long: ( Including Pregnancy)

List any and all medications you are currently taking (include hormones/birth control/non-prescription/herbal remedies)

Are you allergic to any medications?    No. No Known Drug Allergies    Yes: If so please list.

Check all medical conditions that apply to **you**:

- |  |   |                                    |  |
|--|---|------------------------------------|--|
| <input type="checkbox"/> Stroke/ TIA's       | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Asthma    | <input type="checkbox"/> Cancer      Type:_____  |
| <input type="checkbox"/> Vascular Disease    | <input type="checkbox"/> Lung Disease               | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches <input type="checkbox"/> Mental Disabilities        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease            | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Seasonal Allergies  |
| <input type="checkbox"/> Head Trauma         | <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Seizures  | <input type="checkbox"/> Gastro/Intestinal <input type="checkbox"/> Pregnancy ___Weeks |
| <input type="checkbox"/> Past Trauma_____    | <input type="checkbox"/> Other: (Please List) _____ |                                    |  |

Check all eye conditions that apply to **you**:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Eye Surgery   type_____  | <input type="checkbox"/> Cataracts                  | <input type="checkbox"/> Glaucoma      Treated by:_____ |
| <input type="checkbox"/> Lazy Eye                 | <input type="checkbox"/> Strabismus (eye turn)      | <input type="checkbox"/> Keratoconus                    |
| <input type="checkbox"/> Light Flashes            | <input type="checkbox"/> Dry Eyes                   | <input type="checkbox"/> Corneal Transplant             |
| <input type="checkbox"/> Past Eye Injuries: _____ | <input type="checkbox"/> Other: (Please List) _____ |   |

Check conditions that are present in **other** family members:

- |   |   |                                       |   |
|---|---|---------------------------------------|---|
| <input type="checkbox"/> Cataracts before age 60                        | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Cancer      Type:_____                                     |
| <input type="checkbox"/> Macular Degeneration                           | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke/TIA's | <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Other <b>EYE</b> Diseases (please list) _____  |   |                                       |   |
| <input type="checkbox"/> Other Inherited Conditions (please list) _____ |   |                                       |   |

**CONTACT LENS HISTORY**

- Have you ever worn contacts? \_\_\_\_\_
- When was the last time you wore contacts? \_\_\_\_\_
- Are you here for a contact lens prescription today? \_\_\_\_\_
- How many nights a month do you sleep in your contacts? \_\_\_\_\_

**Please check which kind of contacts you currently wear, or are interested in:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Daily Wear (1 pair for the year) | <input type="checkbox"/> Extended Wear (can sleep in)               | <input type="checkbox"/> Disposables: How often do you throw each pair away?_____ |
| <input type="checkbox"/> Rigid Gas Permeable              | <input type="checkbox"/> Bifocal                                    | <input type="checkbox"/> Toric/Astigmatism <input type="checkbox"/> Colors        |
| <input type="checkbox"/> <b>Problems with contacts:</b>   | <input type="checkbox"/> Dry <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Blurry <input type="checkbox"/> Other                    |
| Brand of Current Contacts:_____                           |   | Solution you currently use:_____  |

**WORK ACTIVITIES, HOBBIES, & INTERESTS**

- |   |  |                                       |   |                                       |  |
|---|--|---------------------------------------|---|---------------------------------------|--|
| <input type="checkbox"/> Football/ Basketball | <input type="checkbox"/> Baseball/Softball | <input type="checkbox"/> Gymnastics   | <input type="checkbox"/> Soccer                 | <input type="checkbox"/> Martial Arts | <input type="checkbox"/> Computers _____ hrs/day |
| <input type="checkbox"/> Swim/ Water Sports   | <input type="checkbox"/> Scuba Diving      | <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Dusty work environment | <input type="checkbox"/> Other:       |  |

**Please read and sign the following**

Failure to pay your bill in a timely manner may result in additional charges for interest, documentation fees, bank fees, billing fees, collection agency fees, or any other applicable fees.

Insurance is accepted on good faith is not a guarantee of benefits. In the event your insurance provider determines that you are not eligible for vision insurance coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by your insurance provider.

Patient's/Guardian's Signature:\_\_\_\_\_ Date: \_\_\_\_\_