PATIENT INFORMATION

Today's Date

Patient Name Date of Birth Age Male Female

Address

City State Zip Code

Telephone: Home Work Mobile

Email Address

Employer Occupation

Vision Insurance Provider Policy ID #

Policy Holder Name Do you have Medicare? Yes No

Referred by Date of last vision exam

Are you experiencing vision difficulties? Yes No Distance Near

Have you ever worn contact lenses? Yes No

If yes, when?

Are you interested in wearing contact lenses? Yes No

Do you wear glasses? Yes No

Have you ever had visual therapy or eye exercises? Yes No

If yes, when?

Are you presently taking medications? Yes No

If yes, please list:

YOUR HEALTH HISTORY (please check all that apply)

- Allergies: To what?
- Diabetes
- High blood pressure
- Drug sensitivities: To what?
- Eye surgery: When?
- Glaucoma
- Headaches: Describe
- Eye strain, twitch
- Recent light flashes, spots, floaters

YOUR FAMILY HISTORY

- Diabetes
- Heart disease
- High blood pressure
- Glaucoma