

Name _____ Date _____
Address _____ Phone (h) _____
_____ Phone (w) _____
Employer _____ Occupation _____
Social Security Number _____ Birthdate _____

TO ENABLE US TO SERVE YOUR VISUAL NEEDS AS COMPLETELY AS POSSIBLE PLEASE ANSWER THE FOLLOWING QUESTIONS

Today's exam is for: routine check up eyeglasses contact lenses
Do you have any of the following signs, symptoms, or conditions? red eyes
 eye pain double vision itching, burning, tearing cataracts
 flashes or floaters hypertension diabetes light sensitivity

Previous eye care: eyeglasses contact lenses eye surgery
 vision therapy orthokeratology no prior eye care

Do you presently wear eyeglasses? yes no

If yes, for distance vision near vision all the time

Date of last eye exam: _____ doctor _____ city _____

Was your last visual/eye exam with an optometrist (vision specialist)
 ophthalmologist (eye surgeon)?

When was your last medical exam? month _____ year _____

Your family doctor or physician _____

Are you taking any prescription or over the counter medication? yes no

Do you have a medical condition that may possibly affect your vision
or eye health? yes no

Do you have allergies? yes no

Are you sensitive to any prescription medications/drugs or over the counter
 yes no If yes, please list _____

Do you get headaches? yes no

If yes, seldom occasionally frequently

Do you relate your headaches to an eye problem?

yes no

Is there a family history of any of the following diseases or conditions? cataracts

glaucoma macular degeneration retinal detachment

corneal dystrophy strabismus/amblyopia hypertension

heart disease diabetes thyroid

Have you ever had an eye injury? yes no

Have you ever had an eye disease? yes no

Does sunlight or bright lights bother your eyes? yes no
Do you wear sunglasses? yes no
Do you use a computer at home or at work? yes no
Are you presently having vision problems associated with using
a computer? yes no
What hobbies or sports do you participate in? _____

Please list any special visual tasks that may help us in the prescribing
and fitting of your eyewear _____

Are you currently wearing contact lenses? yes no
If yes, disposable gas permeable hard plastic
 soft daily wear soft extended wear astigmatic soft
 bifocal soft or hard

If you have discontinued contact lens wear, what was the reason?
 vision comfort cost allergies

Were you referred to our office by? friend relative another
 optical office insurance/vision plan yellow pages
 walk-in/drive-by other (please specify)

Do you have vision insurance that may cover the cost of all or part of our
services? yes no

Vision insurance company _____ Policy # _____

Please note that this office does not give cash refunds. If there are questions
regarding this policy please discuss this with the doctor prior to ordering any
materials or eyewear.

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge.
The above questions have been accurately answered. I understand that providing incorrect
information can be dangerous to my health. I authorize the eye doctor to release any information
including the diagnosis and the records of any treatment or examination rendered to me or my
child during the period of such eyecare to third party payers and/or health practitioners. I
authorize and request my insurance company to pay directly to the eye doctor insurance benefits
otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the
actual bill for services. I agree to be responsible for payment of all services rendered on my
behalf or my dependents.

X _____

signature of patient (or parent if a minor)

date

THANK YOU