General Demographic Information

Today's Date (or Date of Exam) _____

Gender ❑ Male ❑ Female Date of Birth _____

Last Name _____

First Name _____ Middle Initial. _____

Title (circle) Mr. Mrs. Miss. Ms. Dr. Rev. Other: _____

Other names used? (Nickname, Maiden, etc) _____

Address _____

City _____ State _____ Zip _____

❑ Home Phone _____

❑ Daytime Phone _____

❑ Cell Phone _____

❑ Ok to Text you?

❑ Email _____

↑*Please check ☑ one of the four choices above as your preferred communication preference.*

*We only use Email addresses for appointment reminders. With your permission, we will also **rarely** send the occasional newsletter or special events.* ❑ Yes ❑ No

Social Security # _____

Please Note: We only use Social Security and Date of Birth information for internal records and for insurance filing if authorized by you.

Employer (or School) _____

Occupation (or Grade) _____

How did you find out about us? _____

Health Care Reform Act Questions:

Preferred Language: ❑ English ❑ Spanish

Ethnicity choices: Are you?

❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Prefer not to answer

Race: Do you consider yourself (Note: Ok to select more than one)

❑ American Indian or Alaskan Native ❑ Asian

❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander

❑ White ❑ Prefer not to answer

Contact Lenses: Do you ...

…currently wear contacts lenses? No Yes

If yes, do you have them on today? No Yes

If no, have you worn them in the past? No Yes

If no, do you have an interest in trying contact lenses? No Yes

If yes, what type of contact do you wear: _____

How often do you replace your contacts? _____

What Contact Lens Solution do you store your contacts in?

❑ Biotrue ❑ Clear Care ❑ Opti-Free ❑ RevitaLens

Other:_____

Your Vision History

What is the primary purpose of this visit? _____

_____

Do you currently experience? (please circle)

Blinking (excessive)	Dry eye(s)	Headaches
Blurred dist. vision	Eye fatigue	Itchy eye(s)
Blurred computer	Eyelid baggy	Light sensitivity/photophobia
Blurred near vision	Eyelid crusty	Loss of side vision
Blurred night vision	Eyelid droopy	Pain
Blurred _____	Eyelid sticky	Red eye(s)
Burning feeling	Eyelid swollen	Sandy/Gritty feeling
Car/motion sickness	Flashes of light	Squinting
Contact lens problem	Floaters in vision	Twitching
Discharge from eye(s)	Foreign body feeling	Watery eyes
Discomfort/Sore	Glare	

Allergies

❑ NONE

Current Prescription Medications (Please allow us to copy your printed Rx list)

❑ NONE

Current Supplements/Vitamins

❑ Vitamin B(s) ❑ Calcium
❑ Vitamin-C ❑ CoQ-10/Ubiquinol
❑ Vitamin-D ❑ Omega-3's (Fish Oil)
❑ Vitamin-E ❑ EyePromise Restore
❑ Multivitamin, if so, what brand?:

❑ NONE

Current Eye Drops Used (Prescription or Over the Counter)

❑ NONE

Your Ocular History (Dry eye, Eye Surgery, Injury, Lazy Eye, Loss of Vision, etc)

Family History **On line, indicate relationship to you: Dad, Mom, Brother, Sister**
***Maternal* Grandparents = MGF or MGM *Paternal* Grandparents = PGF or PGM**

Blindness_____ Cataracts_____ Glaucoma_____ Macular Degen._____

Any other family vision or ocular problems?_____

Cancer_____ Diabetes_____ Heart Disease_____ Hypertension_____

Any other family medical problems?_____

Do you …

...Currently wear glasses? No Yes

…Wear bifocals/multifocal? No Yes

Are you interested in…

…Refractive Surgery No Yes

…Looking at new glasses? No Yes