WELCOME TO THE OFFICE



Last name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age \_\_\_\_\_\_\_\_\_Gender\_\_\_\_\_\_\_\_\_\_ Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_

Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names/ages of children at home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address (if different from above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of last eye exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you wear **eyeglasses** please answer questions #1-9 Yes No

1. Would you like your glasses to be thinner or lighter?

2. Do you want to protect your eyes from damaging UV sun rays?

3. Do you want your lenses to be more resistant to scratching?

4. Do you want your lenses to get darker in the sun?

5. Do you want your lenses to almost look invisible in the frame?

6. Would you like to minimize glare and reflections when driving at

night or at the computer?

7. Are you ever bothered by bright sunlight and glare outdoors?

8. If you wear sunglasses, does it ever seem they’re not dark enough?

9. Do your glasses slip down your nose or hurt behind your ears?

If you wear **contact lenses** please answer questions #10-16

10. What brand of contacts do you wear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. How often do you replace your contacts?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. What solutions are used to clean/disinfect your contacts?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No

13. Are you satisfied with the vision your contacts provide?

14. Do your contacts dry out or become less comfortable as the day wears on?

15. Is your daily wearing time shorter than you would like?

16. Do your contacts have a tendency to make your eyes red or irritated?

17. Are you interested in learning if you are a good candidate

for laser vision correction/LASIK?

What is your main reason for coming in today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please turn page over and complete other side

**Health history**: Please circle all conditions that apply to you or your immediate family (parents and siblings)

Allergies Me Family Eye turn Me Family

Cancer Me Family Eye surgery Me Family

High cholesterol Me Family Color blindness Me Family

Diabetes Me Family Cataracts Me Family

Headaches Me Family Blindness Me Family

Heart disease Me Family Dry eyes Me Family

High blood pressure Me Family Flashes of light Me Family

Migraines Me Family Floaters Me Family

Respiratory disease Me Family Light sensitivity Me Family

Thyroid Me Family Glaucoma Me Family

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lazy Eye Me Family

Retinal detachment Me Family

When was your last medical exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications (prescription, over the counter, vitamins, etc) on a regular basis?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work history**

Do you use a computer at work at home? Yes No Hours/day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience any of the following when you use your eyes? Please circle

* Headaches • Lose place when reading
* Letters blur • Poor night vision
* Red or watery eyes when reading • Eyes blur in/out of focus
* Double vision • Eyes blur at far
* Eyestrain • Poor comprehension when reading
* Street signs blurry at end of day • Skipping over words/lines when reading
* Get sleepy • More effort required to see clearly at end of day

**Avocational history**

Which of the following do you do? Read, racquetball, golf, baseball, swim, camp, play cards, sew, craft, fly, fish, video games, musical instruments, other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For parents with school age children** Yes No

Have any of your children ever had difficulty in school?

Have they ever been described as not working up to potential?

Do you feel your children could do better in school?

Do your children like to read?

Have your children ever been diagnosed as ADD/ADHD?

Are your children reading below grade level?

Are your children in special education classes?

Thank you for choosing our office