WELCOME! Please fill out this form completely. Thank you. **Please Print Neatly:**

Name: _____ Nickname:_____Referred By:_____

Occupation:_____ Employer:_____
Preferred Language ☐ English☐ Other_____ ☐**Decline**
Race☐ American Indian or Alaska Native☐ Asian☐African American☐Native Hawaiian or Other Pacific Islander
☐ Caucasian☐ Hispanic or Latino☐All other races☐**Decline**

Are you satisfied with your vision at the present time? ☐ Yes ☐ No
Are you having any of the following vision concerns? ☐ Blurred Vision ☐ Eyestrain ☐ Eye Pain ☐ Severe Sensitivity to Lights
☐ Headache ☐ Poor Night Vision ☐ Bothersome Night Glare ☐ Double vision ☐ Total Loss of Vision☐ **None**

Are you having any of the following concerns? ☐ Redness ☐ Burning ☐ Itching ☐ Tearing ☐ Discharge☐ **None**

Have you ever been diagnosed with any of the following conditions: ☐ Cataract ☐ Age Related Macular Degeneration ☐ Glaucoma
☐ Diabetic Retinopathy ☐ Dry Eye☐ Eye Infection, Inflammation, or Allergy ☐ Floaters and/or Flashes of Light
☐ Iritis or Uveitis ☐ Cataract☐ Retina Defects or Degenerations☐ **None**

When was your last eye exam? When:_____ Dr._____
When do you wear your glasses? ☐ I do not have glasses ☐ Always ☐ For distance ☐ For close work ☐ Never
☐ For computer work ☐ When I am not wearing my contacts If you have glasses, how old are they?_____
Hobbies/Sports: ☐ Outdoor Activities ☐ Fishing ☐ Boating ☐ Sport Shooting ☐ Motorcycles ☐ Golf ☐ Running/Walking
☐ Cycling ☐ Skiing ☐ Carpentry ☐ Sports_____☐ Other:_____

Do you work at a computer terminal? ☐ Yes ☐ NoHours per day?_____
Do you have any special visual demands? (Sports, Hobbies, Etc.) ☐ Yes ☐ No Describe:_____

Have you ever worn contact lenses? ☐ Yes ☐ No
Are you interested in contact lenses? ☐ Yes ☐ No
Do you now wear contact lenses? ☐ Yes ☐ No What type?_____Hours per day?_____Age of lenses?_____
On average, how many hours per day do you wear your glasses? _____ hours

Are you interested in laser vision correction? ☐ Yes ☐ No
Are you interested in eliminating the need for glasses or contact lenses non-surgically? ☐ Yes ☐ No

When was your last medical (physical) exam by a physician?_____Dr._____
Do you take any medication? ☐ Yes ☐ No
Name of medications:_____ its purpose _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have any medication allergies: ☐ None ☐ Yes; Please list:_____
Do you have any other allergies: ☐ None ☐ Yes; Please list:_____

Please continue on the other side

For In Office Use
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AYPTGNGT?❑ Y ❑ N ❑ IN **CL?**❑ Y ❑ N ❑ IN IOP: OD:_____ OS:_____❑ VF Normal
DFE: ❑ Yes ❑ RTO ❑ Refused ❑ If Necessary ❑ CND ❑ Refused
Optomap: ❑ Med Map ❑ Screening ❑ RTO ❑ Refused ❑ If Necessary ❑ Comp: Vet ❑ Comp: Preg
❑ NWB ❑DNB
First RX: #_____ Identifier:_____ Second RX: #_____ Identifier:_____

OD						OD						
OS						OS						

❑ FT ❑ Trif ❑ Pal ❑ FT ❑ Trif ❑ Pal

Please check all that apply to a review of your health:

Overall Health: ☐ **None**
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other

Ear, Nose & Throat: ☐ **None**
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other

Neurological: ☐ **None**
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ Migraine
- ☐ Other

Psychiatric: ☐ **None**
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Other

Cardiovascular: ☐ **None**
- ☐ Hypertension
- ☐ Stroke/CVA
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Other

Respiratory: ☐ **None**
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other

Gastrointestinal: ☐ **None**
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflex
- ☐ Celiac Disease
- ☐ Other

Genitourinary: ☐ **None**
- ☐ Kidney Disease
- ☐ Prostate Disease/cancer
- ☐ STD – Herpetic/Chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia
- ☐ Other

Musculoskeletal: ☐ **None**
- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other

Integumentary: ☐ **None**
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ HSV/cold sores
- ☐ Herpes Zoster/Shingles
- ☐ Other

Endocrine: ☐ **None**
- ☐ Type 2 Diabetes Mellitus
  # of years:_____
  AIC:_____ Glucose level:_____
- ☐ Type 1 Diabetes Mellitus
  # of years:_____
  AIC:_____ Glucose level:_____
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other

Hematologic/Lymphatic: ☐ **None**
- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesteremia
- ☐ Other

Allergic/Immune: ☐ **None**
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Other

Have you ever had any eye disease, eye injury, and or eye surgery? ☐ Yes ☐ No
Describe:_____

Do you consume alcohol? ☐ No ☐ Yes Amount: ☐ Minimal ☐ Moderate ☐ Excessive
Do you use tobacco products? ☐ No ☐ Yes ☐ Cigarettes or_____Frequency:_____

Does any family member have any of the following? ☐ Cancer ☐ Diabetes Mellitus ☐ Hypertension ☐ Hyperthyroidism ☐ Hypothyroidism
Does any family member have any of the following? ☐ Cataract ☐ Age Related Macular Degeneration ☐ Other:_____

Approximate height: ___feet ___inches Approximate weight:_____lbs

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Method of Payment? ☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit
Do You Have Optical Insurance? ☐ Yes ☐ No Who?_____
Do You Have Medical Insurance? ☐ Yes ☐ No Who?_____