Patient's Name ______________________________ SSN# ________________

Patient's Address ____

Home Phone: __________ Daytime Phone: __________ Cell: ______________

My visit for today is for: (CIRCLE ONE) Glasses Contacts Office Visit
Other: ____

Date of Last eye exam: ______________________ Doctor: ________________
Would you like to set up a free Lasik consultation? YES NO

Are you allergic to any medications? YES NO
(If so, please list) ____
LIST ALL MEDICATIONS YOU ARE TAKING: ________________
____
____
And for what? ____

THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL.
Do you drive? YES No
If yes, do you have visual difficulty when driving? YES NO

Do you use tobacco products? YES NO
If yes, type/how long/amount: ______________________________

Do you drink alcohol? YES NO
If yes, type/how long/amount: ______________________________
Have you ever been exposed to or infected with any sexually transmitted disease?
If so please give details: ______________________________

Have you ever had any of the following?
Eye injuries (FOREIGN OBECTS, BLACK EYES, ETC.) YES NO
Eye disease (CATARACT, GLAUCOMA, MACULAR DEGENERATION) YES NO
Eye surgery (CATARACT, LASIK, ETC.) YES NO
If yes to any of the above, please tell what and when: ________________
____

Do you…(Check if answer is YES)
- o Wear contacts? If so, what brand ________________
- o Work at a computer?
- o Spend time outdoors? How much? __________ Hrs per week
- o Think you might benefit from thinner, lighter lenses?
- o Have prescription sunglasses?
- o Prefer not to wear your glasses at times
- o Have interest in a non-surgical approach to vision correction?
- o Have more than 1 pair of CURRENT prescription glasses?
- o Have children?
- o Have family member in need of eye care?

If you wear bifocals, does the lines or head tilting bother you? YES NO
If you wear contacts, are you satisfied with your vision and comfort? YES NO

Do you CURRENTLY have any problems in the following areas?

EYES
- o Eye pain or soreness
- o Fatigue/tired eye
- o Dry/gritty feeling
- o Redness
- o Burning
- o Itching
- o Excess watering
- o Discharge
- o Squinting
- o Glare/light sensitivity
- o Halos around lights
- o Double Vision
- o Loss of vision
- o Blurred Vision
- o Flashes
- o Floaters

ALLERGIES
- o Seasonal
- o Sinus infections
- o Mold, pollen, cedar, grass

CARDIOVASCULAR
- o Heart disease/problems
- o High blood pressure
- o Elevated cholesterol
- o Stroke

CONSTITUTIONAL
- o Weight gain
- o Weight loss

ENDOCRINE
- o Thyroid disorder
- o Diabetes
- o Gout

EAR, NOSE, THROAT, MOUTH
- o Ear Infections
- o Hearing loss

SKIN
- o Acne rosacea
- o Lupus
- o Rashes/sores

RESPIRATORY
- o Asthma
- o Chronic bronchitis
- o Emphysema

GASTROINTESTINAL
- o Acid reflux
- o Heartburn
- o Liver/Colon Cancer
- o Pancreatitis

GENITOURINARY
- o Bladder infections
- o Cancer

LYMPHATIC/HEMATOLOGIC
- o Anemia
- o Bleeding disorder
- o Blood clots

MUSCULOSKELETAL
- o Rheumatoid arthritis
- o Muscle/joint pain
- o Osteoporosis

NEUROLOGICAL
- o Headaches
- o Seizures
- o Depression
- o Psychiatric disorder
- o Schizophrenia