Name _____Today's date_____
Address_____Apt_____
City_____State __ Zip _____
Home Phone _____ work _____
Cell Ph _____ email_____
Reason for this visit _____
_____
Do you prefer to be contacted by email or text message? Check ☐email or ☐text message

Birth date _____ Sex_____
Employer _____ Position _____
SSN_____Insured's SSN _____
Date of last eye exam _____
Family members still living at home:
Spouse _____ Age ____
Name _____ Age ____
Name _____ Age ____

Check all that you are sensitive to:
☐lights ☐fluorescent lights ☐glare
☐snow ☐headlights ☐sun

Hobbies _____ Sports _____

How many hours do you work with a computer? _____

List your medications _____
_____

Any personal or family history of: (check)
☐glaucoma ☐high blood pressure ☐allergies
☐diabetes ☐retinal disease

Do you smoke, drink alcohol or take illegal drugs? _____
How old are your glasses? _____
How old are your contacts?_____

Are you interested in contacts? _____

Ever had vision therapy? _____

Ever had an eye injury or surgery? _____

Do you have: (check all that apply)
☐flashing lights ☐burning eyes ☐floaters
☐double vision ☐itching eyes ☐headaches
☐sinus problems ☐pain in eyes ☐tearing
☐night driving problems

Whom may we thank for referring you to us? _____
_____