PERSONAL INFORMATION

Last ____

First ____________________________________ MI __________

Address ____

City_______________________ ST_______Zip______________

Sex M F DOB_________________ Age______________

Phone Number____

Phone (Alt)____

Email____

Occupation____

Emergency contact _______________________________________

phone number ___________________relationship ____________

MEDICAL

Are you taking any prescription medications? N Y

If yes please list: ____

____

Are you allergic to any prescription medications? N Y

If yes, Please List: _______________________________________

____

Do you smoke? N Y Do you use alcohol? N Y Social

Are you pregnant? N Y Are you nursing a baby? N Y

Have you had any substance abuse treatment? N Y

Are you experiencing any of the following?

Burning/itching	Dry eyes	Double vision
Light sensitivity	Watery eyes	Twitching eyelids
Mucous discharge	Eye pain	Unexplained Headaches
Flashing lights	New floaters	

Have you or a family member been diagnosed with or treated for any of the following? Please mark S for self or F for family

___Macular Degeneration	___Iritis/Uveitis	___Diabetes
___Crossed Eye/Strabismus	___Eye Infection	___Depression
___High Blood Pressure	___Tuberculosis	___Migraines
___Lazy eye/Amblyopia	___Stroke/TIA	___Glaucoma
___Diabetic Eye Disease	___Cataract	___Cancer
___Retinal hole/Tear/Detach	___Asthma/COPD	___ADIS/HIV
___Permanent vision loss	___Thyroid Disease	___Mental Disorder
___Heart Attack/Disease	___Corneal Ulcer	___Hepatitis

EYEWEAR NEEDS ASSESSMENT

Do you currently wear eyeglasses? N Y

All the time	Occasionally	TV
Reading	Driving	Sports

Do your current eyeglasses satisfy your visual needs? Y N

explain____

____

Does your daily routine involve a lot of driving? Y N

Does glare bother you? Y N

Do you wear sunglasses? Y N

Do you have trouble seeing at night? Y N

How many hours a day do you spend looking at a computer screen or other electronic device? _________

Is focusing both near and far challenging to you? Y N

Does detailed work or small print strain your eyes? Y N

Do you participate in active or competitive sports? Y N

What type?

____

Do your current glasses fit comfortably? Y N

What would you change about your current eyeglasses?

____

Are you considering trying contact lenses or do you need to update your contact lens prescription? (If your prescription is over 1 year old the prescription will need to be updated) Y N

What Type of contact lens do you currently wear?

____

What is the main reason for your visit with us today?

____

Do you have any specific questions for the Doctor? Y N

____

____

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

I have read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payments, or health care options. I also understand that this organization has the right to change its Notice of Privacy from time to time and that I May contact this organization at any time to obtain a current of the of the **Notice of Privacy Practices**.

____ ___________________

Signature Date

Reviewed by ____________________________________ MD / OD Date: ____________________________