Patient Name: ______________________________________ Date of Birth________________

REASON FOR VISITING OUR OFFICE (please check all that apply):

<u>Annual (Well-Vision) Exam</u>
Contact Lens Exam (*please complete our survey form*)
Blurred Near and/or Distance Vision
Trouble Seeing at Night
Computer Eye Strain
Lost or Broken Glasses
Lenses are Scratched
Want New Glasses
Want Thinner/Lighter Glasses

<u>The Below Symptoms May Require a Medical Exam</u>
Headaches
Eyes: burn itch water feel tired feel dry
Flashes of Light
Floaters (black specks & spots)
Foreign Body (something in the eye)
Other (please explain):
____
____

When was your last eye exam (month/year)? ________________________________ or please approximate below:
Less than 1 Year 1-2 Years 3+ Years Unknown Never

Where was your last eye exam (office name/doctor name)? _____________________ or please approximate below:
School MVD Physician's Office Mall Nationwide Vision Vision Works Not Sure

<u>MEDICAL CONDITIONS:</u> <u>Please check</u> **("S" for self)** or **("F" for family)** or if none apply, please mark **None**

Ocular History: None

	S	F		S	F
Glaucoma			Cataracts		
Macular Degeneration			Blindness		
Retinal Detachment			Eye Infections/Ulcers		
Retinal Tear/Hole			Eye Surgery/Injury		
Amblyopia (lazy eye)			Flashes/Floaters		
Strabismus (eye turn)					

Medical History: None

	S	F		S	F
High Blood Pressure			Diabetes		
Heart problems			High Cholesterol		
Thyroid problems			Allergies		
Cancer/Tumors			Sinus problems		
Arthritis			Headaches		
Lupus			Pregnant		

Do you smoke? Yes No If yes, please indicate frequency ____________________________

Please provide primary care physician info including phone number, date of last visit & any other pertinent health info.

____

Please list all the medications you are currently taking or write NONE

____
____
____

Do you have any allergies to medications? (Please list all that apply) or write NONE

____

Do you have/ have you had any injuries, major surgeries, illnesses, and/or diseases? Please describe below:

____
____
____

I certify that the medical information provided is as current and accurate as possible.

Patient or Guardian Signature: ____ Date _______________

Guardian Printed Name: ____