WELCOME TO OUR OFFICE

Name	**Birth Date** **Age**
Address	**Pt. Social Security #**
City, State, Zip	Medical Insurance/ID
Home Phone	**Vision Insurance/ID**
Work Phone	**Employer :**
Cell Phone	**Occupation:**
E-mail	**Primary Insured name:**
How did you hear about us?	**Primary Social Security #** Date Of Birth:

When and where was your last eye exam?_____

Are you experiencing or have you had one of the following:

- ☐ red eyes
- ☐ itchy eyes
- ☐ watery eyes
- ☐ dry eyes
- ☐ burning eyes
- ☐ eye mucous
- ☐ blurred vision
- ☐ eye strain
- ☐ headaches
- ☐ double vision
- ☐ floaters
- ☐ flashing lights
- ☐ sensitivity to light
- ☐ seasonal allergies
- ☐ eye surgery
- ☐ eye infection
- ☐ eye trauma

Have you or any of your family members ever been diagnosed with:

Please mark "S" for self or "F" for a family member:

- glaucoma ____
- macular degeneration ____
- amblyopia (lazy eye) ____
- retinal detachment ____
- strabismus ____
- cataracts ____
- diabetes ____
- high blood pressure ____
- heart disease ____
- thyroid disease ____
- kidney disease
- asthma ____
- HIV ____
- arthritis ____
- other _____

Are you presently taking or recently discontinued any medications, hormones or birth control pills?
(Please list) _____
_____

Are you allergic to any medications or have any other allergies? (Please list)_____
_____

Do you wear contact lenses? Y or N **What brand do you wear?**_____
Would you like to be fitted for contact lenses? Y or N

List any problems you are having with your current contacts or glasses: _____
_____

Are you interested in finding out if you are a candidate for Laser Vision Correction? Y or N

*All prescriptions for glasses and contacts will expire in one year and will not be filled or released thereafter.