WELCOME! Please fill out this form completely. Thank you.

Name: ❑ Mr ❑ Mrs ❑ Ms ❑ Dr ❑ Prof ______________________________ Nickname:________________

Referred By:__________________________________

Occupation:____________________________ Employer:_________________________

Email:____

Preferred Language: ❑ English ❑ Other_____________ Race: ❑ American Indian or Alaska Native ❑ Asian ❑ African American ❑ Native Hawaiian or Other Pacific Islander ❑ Caucasian ❑ Hispanic or Latino ❑ All other races ❑ Decline

Are you satisfied with your vision at the present time? ❑ Yes ❑ No

Are you having any of the following vision concerns? ❑ Blurred Vision ❑ Eyestrain ❑ Eye Pain ❑ Severe Sensitivity to Lights ❑ Headache ❑ Poor Night Vision ❑ Bothersome Night Glare ❑ Double vision ❑ Total Loss of Vision ❑ None

Are you having any of the following concerns? ❑ Redness ❑ Burning ❑ Itching ❑ Tearing ❑ Discharge ❑ None

During a typical day in the past month, how often did your eyes feel discomfort?

❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently ❑ Constantly

When your eyes felt discomfort, how intense was the feeling of discomfort at the end of the day, within two hours of going to bed?

Never have it	Not at all intense				Very intense
❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

During a typical the day in the past month, how often did your eyes feel dry?

❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently ❑ Constantly

When your eyes felt dry, how intense was the feeling of dryness at the end of the day, within two hours of going to bed?

Never have it	Not at all intense				Very intense
❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

During a typical day in the past month, how often did your eyes look red or feel excessively watery?

❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently ❑ Constantly

Have you ever been diagnosed with any of the following conditions: ❑ Cataract ❑ Age Related Macular Degeneration ❑ Glaucoma ❑ Diabetic Retinopathy ❑ Dry Eye ❑ Eye Infection, Inflammation, or Allergy ❑ Floaters and/or Flashes of Light ❑ Iritis or Uveitis ❑ Retina Defects or Degenerations ❑ None

When was your last eye exam? When______________ Dr.____________________

When do you wear your glasses? ❑ I do not have glasses ❑ Always ❑ For distance ❑ For close work ❑ Never ❑ For computer work ❑ When I am not wearing my contacts

If you have glasses, how old are they?_____________

Hobbies/Sports: ❑ Outdoor Activities ❑ Fishing ❑ Boating ❑ Sport Shooting ❑ Motorcycles ❑ Golf ❑ Running/Walking ❑ Cycling ❑ Skiing ❑ Carpentry ❑ Sports:_____________________ ❑ Other:___________________________________

Do you work at a computer terminal? ❑ Yes ❑ No Hours per day?______________

Do you have any special visual demands? (Sports, Hobbies, Etc.) ❑ Yes ❑ No

If yes, please describe:____

Have you ever worn contact lenses? ❑ Yes ❑ No

Are you interested in contact lenses? ❑ Yes ❑ No

Do you now wear contact lenses? ❑ Yes ❑ No

What type?________________________Hours per day?______Age of lenses?_______

If you wear contact lenses, how many hours per day do you wear your glasses? _________ hours

If you wear contact lenses, do you wear them every day? ❑ Yes ❑ No

Are you interested in laser vision correction? ❑ Yes ❑ No

Are you interested in eliminating the need for glasses or contact lenses non-surgically? ❑ Yes ❑ No

When was your last medical (physical) exam by a physician?________________Dr.______________

Do you take any medication? ❑ Yes ❑ No

Name of medications:	its purpose
___________________________	_______________________
___________________________	_______________________
___________________________	_______________________
___________________________	_______________________
___________________________	_______________________
___________________________	_______________________
___________________________	_______________________
___________________________	_______________________
___________________________	_______________________

Please list your preferred pharmacy and pharmacy location: ____

Do you have any medication allergies: ❑ None ❑ Yes; Please list:____

Do you have any other allergies: ❑ None ❑ Yes; Please list:____

Please check all that apply to a review of your health:

Overall Health:
- ❑ **No Health Problems**
- ❑ Developmental Disabilities
- ❑ Cancer
- ❑ Fatigue Syndrome
- ❑ Other

Ear, Nose & Throat:
- ❑ None
- ❑ Hearing Loss
- ❑ Sinusitis
- ❑ Dry Mouth
- ❑ Laryngitis
- ❑ Other

Neurological:
- ❑ None
- ❑ Multiple Sclerosis
- ❑ Epilepsy
- ❑ Cerebral Palsy
- ❑ Tumor
- ❑ Stroke/CVA
- ❑ Migraine
- ❑ Other

Psychiatric:
- ❑ None
- ❑ Depression
- ❑ Attention Deficit
- ❑ Anxiety Disorder
- ❑ Bipolar Disorder
- ❑ Other

Cardiovascular:
- ❑ None
- ❑ Hypertension
- ❑ High Cholesterol
- ❑ Stroke/CVA
- ❑ Heart Disease
- ❑ Vascular Disease
- ❑ Congestive Heart Failure
- ❑ Other

Respiratory:
- ❑ None
- ❑ Cigarette Smoker
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Chronic Obstruction
- ❑ Sleep Apnea
- ❑ Other

Gastrointestinal:
- ❑ None
- ❑ Crohn's
- ❑ Colitis
- ❑ Ulcer
- ❑ Acid Reflex
- ❑ Celiac Disease
- ❑ Other

Genitourinary:
- ❑ None
- ❑ Kidney Disease
- ❑ Prostate Disease/cancer
- ❑ STD – Herpetic/Chlamydia
- ❑ Benign Prostate Hypertrophy
- ❑ Pregnant
- ❑ Nursing
- ❑ Herpes
- ❑ Chlamydia
- ❑ Other

Musculoskeletal:
- ❑ None
- ❑ Arthritis
- ❑ Osteoarthritis
- ❑ Fibromyalgia
- ❑ Muscular Dystrophy
- ❑ Ankylosing Spondylitis
- ❑ Osteoporosis
- ❑ Gout
- ❑ Other

Integumentary:
- ❑ None
- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis
- ❑ HSV/cold sores
- ❑ Herpes Zoster/Shingles
- ❑ Other

Endocrine:
- ❑ None
- ❑ Type 2 Diabetes Mellitus
  Year diagnosed:_______ AIC:_____
  Glucose level: _________
- ❑ Type 1 Diabetes Mellitus
  Year diagnosed:_______ AIC:_____
  Glucose level: _________
- ❑ Thyroid Dysfunction
- ❑ Hormonal Dysfunction
- ❑ Other

Hematologic/Lymphatic:
- ❑ None
- ❑ Anemia
- ❑ Large Volume Blood Loss
- ❑ Ulcer
- ❑ Hypocholesteremia
- ❑ Other

Allergic/Immune:
- ❑ None
- ❑ Drug Allergies
- ❑ Environmental Allergies
- ❑ Rheumatoid Arthritis
- ❑ Lupus
- ❑ Sjogren's syndrome
- ❑ Other

Have you ever had any eye disease, eye injury, and or eye surgery? ❑ Yes ❑ No Describe:____

Do you consume alcohol? ❑ No ❑ Yes Amount: ❑ Minimal ❑ Moderate ❑ Excessive
Do you use tobacco products? ❑ No ❑ Yes ❑ Cigarettes or____________Frequency:___________

Does any family member have any of the following? ❑ Cancer ❑ Diabetes Mellitus ❑ Hypertension ❑ Hyperthyroidism ❑ Hypothyroidism
Does any family member have any of the following? ❑ Cataract ❑ Age Related Macular Degeneration ❑ Glaucoma ❑ Other:____________

Approximate height: ___feet ___inches Approximate weight:_______lbs

Method of Payment? ❑ Cash ❑ Check ❑ Credit Card ❑ Amex ❑ Care Credit
Do You Have Optical Insurance? ❑ Yes ❑ No Who?_______________________
Do You Have Medical Insurance? ❑ Yes ❑ No Who?_______________________

For In Office Use

AYPTLAGT: ❑ Y ❑ N ❑ IN **CL:** ❑ Y ❑ **N** ❑ IN **IOP: OD**________ **OS**________ **MPOD:**_________ **VF:** ☐Normal ☐ CND
DFE: ❑ Y ❑ No ❑ RTO ❑ Refused ❑ If Necessary **OPTMAP:** ❑ Screening ❑ Med Map ❑ RTO ❑ Refused Comp: ❑ Vet ❑ Preg