

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

Name:  Mr  Mrs  Ms  Dr  Prof \_\_\_\_\_ Nickname: \_\_\_\_\_

Referred By: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

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

Do you have any of the following symptoms:  Dryness  Irritation  Burning  Tearing  Itching  Discharge  Redness  None

Report the **FREQUENCY** of your symptoms using the rating list below:

0 = Never 1 = Sometimes 2 = Often 3 = Constant Symptoms

	0	1	2	3
Dryness, Grittiness, or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the **SEVERITY** of your symptoms using the rating list below:

0 = No Problems 1 = Tolerable 2 = Uncomfortable 3 = Bothersome 4 = Intolerable Symptoms

	0	1	2	3	4
Dryness, Grittiness, or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

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? \_\_\_\_\_

<p>For Office Use Only: Total SPEED Dry Eye Score: ___/28</p>
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