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

Name: ❑ Mr ❑ Mrs ❑ Ms ❑ Dr ❑ Prof _____ Nickname:_____

Date of Birth: _____/_____/_____

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?_____

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