Name:

Address:

Phone:

1. **Reason for your visit?**

2. **Are you having any of the following eye concerns?**

Blurry Vision	Poor Night Vision	Total Loss of Vision	Discharge
Eyestrain	Severe Sensitivity to Lights	Redness	Allergies
Headache	Double Vision	Itching	Dryness
Bothersome Night Glare	Eye pain	Burning	Floaters
		Tearing	

3. **If you wear contact lenses, do you like them? When are you having issues? Is the comfort, ok (dryness)?**

☐ Monovision

☐ Multifocal

4. **If you wear glasses, are you having any issues with your glasses?**

Distance

Computer

Near

5**. How often do you experience any of these symptoms?**

	1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
Headaches	○	○	○	○	○
Pain in Neck/Shoulders	○	○	○	○	○
Discomfort with Computer	○	○	○	○	○
Tired Eyes	○	○	○	○	○
Dry Eye Sensation	○	○	○	○	○
Light Sensitivity	○	○	○	○	○
Dizziness	○	○	○	○	○

6. **Any changes with your medical history (new diagnosis)?**

7. **Any changes with your medication(s)?**

8. **Any new allergies?**

9. If you are diabetic, what was your last A1C?

10. Do you wear Neurolenses?

10. Do you have any other concerns?