Name:

Address:

Phone:

1. **Reason for your visit?**

2. **Have you ever been diagnosed with any of the following eye conditions?**

Eye Infection	Cataracts	Floaters or Flashes of Light	Diabetic Retinopathy
Allergy	Glaucoma	Retina Defects or Degenerations	Other
Dry Eye	Macular Degeneration		
Iritis or Uveitis			

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

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

4. **Tell us about your current corrective lenses.**

Far/Distance Vision:	Acceptable	May Need Improvement	Blurry
Near/Reading Vision:	Acceptable	May Need Improvement	Blurry
Computer Vision:	Acceptable	May Need Improvement	Blurry

5. **Any injuries or surgeries to your eyes?**

6. **Do you smoke?**

7. **Do you drink?**

8. **What contact lenses do you wear (brand and power)?**

9. **Do you use the computer for extended periods?** **Hours per day?**

10. **What hobbies do you have?**

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11. **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	○	○	○	○	○

12. **Do you have any of the following health conditions?**

Hypertension	Congestive Heart Failure	Hyperthyroidism	Bipolar
Diabetes	Asthma	Hypothyroidism	PTSD
High Cholesterol	COPD	Depression	ADHD
Cancer		Anxiety	

13. **What medication do you take?**

14. **Do you have any medication allergies?**

15. **Family Medical History of:** Cancer, Diabetes Type 1 or 2, Hypertension, Hypo/Hyperthyroidism, Cataracts, Glaucoma, Degenerative Disorder of Macula or Other? Please write it down

Mom:

Dad:

Brother:

Sister

Son:

Daughter: