PATIENT HISTORY FORM

DATE _____ PATIENT NAME_____MALE FEMALE

1. WHAT IS THE MAJOR REASON FOR HAVING YOUR EYES EXAMINED TODAY?
_____ ROUTINE EXAMINATION
_____ WISH TO PURCHASE NEW EYEGLASSES OR SUNGLASSES
_____ WISH TO PURCHASE CONTACT LENSES
ANY PROBLEMS WITH OLD CONTACTS?
DRYNESS POOR VISION OTHER_____
_____ WISH INFORMATION ABOUT LASIK EYE SURGERY
_____ DECREASE IN DISTANCE VISION _____ DECREASE IN COMPUTER VISION
_____ DECREASE IN NEAR VISION
_____ EYESTRAIN _____ PROBLEMS WITH GLARE: NIGHT COMPUTER
_____ HEADACHES
_____ DRY EYES _____ ALLERGIES
OTHER REASON, PLEASE EXPLAIN _____

2. DO YOU CURRENTLY WEAR:_____EYEGLASSES _____CONTACT LENSES

3. PLEASE LIST ANY QUESTIONS OR CONCERNS THAT YOU WOULD LIKE ADDRESSED TODAY
_____

4. IF YOU ARE NEW TO OUR OFFICE, WHEN WAS YOUR LAST EXAM? _____

5. HAVE YOU EVER HAD ANY EYE SURGERY, SERIOUS INJURY OR PROBLEMS WITH YOUR EYES?
_____

6. LIST ANY GENERAL HEALTH PROBLEMS YOU HAVE, **CIRCLE ALL THAT APPLY**. DIABETES
HIGH BLOOD PRESSURE HIGH CHOLESTEROL CANCER GLAUCOMA OTHER PROBLEMS
_____

7. PLEASE LIST ANY MEDICATIONS YOU ARE TAKING _____
_____

8. PLEASE LIST MEDICATIONS YOU ARE ALLERGIC TO _____

9. INSURANCE COMPANIES AND MEDICARE REQUIRE US TO ASK IF YOU SMOKE OR CONSUME ALCOHOLIC BEVERAGES. CIRCLE WHICH APPLY
SMOKE ALCOHOL

10. CIRCLE WHICH OCCUR IN YOUR FAMILY: GLAUCOMA MACULAR DEGENERATION DIABETES
HIGH BLOOD PRESSURE OTHER _____
_____

I UNDERSTAND THAT I MUST BE SATISFIED WITH THE PURCHASE OF MY FRAME AS THERE IS NO RETURN POLICY DUE TO DISSATISFACTION OF MY FRAME CHOICE, COLOR OR SIZE. IF I CHOOSE TO REPLACE MY FRAME I UNDERSTAND THAT I AM RESPONSIBLE FOR THE COST OF NEW LENSES AND FRAME AT A REDUCED COST.

SIGNED: _____

OFFICIAL USE ONLY

PREVIOUS GLASSES RX DR. REVIEWED FORM_____

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