Welcome To Our Office

Today's Date ______________________________

Patient Information

Last ______________________________________
First ____________________MI ______________
Street ____________________________________
City ______________ State ________________
Zip Code __________________________________
Home Phone ________________________________
Work Phone ________________________________
Cell Phone ________________________________
Email Address _____________________________
How do you prefer to be contacted?
(Indicate #1 and #2 Choice):
Home #___Work #___Cell #___Text___ Email____
Employer (or School) ______________________
Occupation (or Grade) _____________________
Date of Birth __________________Age ________

Who may we thank for referring you to our office?
Name of friend or relative ____________________
If not referred, how did you choose our office?
❑ Another Dr.
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____________
❑ Web Page: Which Web Site? ________________
❑ Other ____________________________________

Patient Eye History

Date of Last Eye Exam __________________________
By Whom? _____________________________________

How long has it been since you've worn contact lenses?
____

Have you had any eye surgeries?
❑ Yes ❑ No

Have you ever been treated for an eye condition/infection?
❑ Yes ❑ No

Patient Medical History

Name of Family Physician_______________________
Town_____________________________________
Date of Last Physical Check-up__________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)______________________________
____
____
____

Allergies to any foods or medications? ❑ Yes ❑ No
If yes, please list______________________________
____

Are you currently pregnant?	❑ Yes	❑ No
Do you use cigarettes/tobacco?	❑ Yes	❑ No
Do you drink alcohol?	❑ Yes	❑ No
Do you have a history of drug use?	❑ Yes	❑ No

Height _______________ Weight________________

Have you ever been diagnosed or treated for the following health problems? (Blank responses will be interpreted as no)

	Yes
Allergies	❑
Arthritis	❑
Bronchitis	❑
Cancer	❑
Cholesterol	❑
Diabetes	❑
Digestive	❑
Ears/Nose/Throat	❑
Endocrine	❑
Eczema/Rashes	❑
Fatigue	❑
Fevers	❑
Genitourinary	❑
Heart Disease	❑
High Blood Pressure	❑
Kidney	❑
Muscle/Bone	❑
Neurological	❑
Psychological	❑
Respiratory	❑
Sinus	❑
Thyroid	❑
Unusual weight losses/gains	❑

Other conditions not listed:________________________
____

Lifestyle Questionnaire

Do you……(check box if your answer is yes)

❑..think you might benefit from thinner, lighter lenses?

❑..spend time outdoors? How much? __Hrs/week

❑..have prescription sunwear?

❑..have glasses get in the way during these activities?

❑Home ❑Work ❑Social ❑Active

❑..need to hold phone/small print at arm's length?

❑..have interest in learning more about contact lenses?

❑..have interest in learning more about laser vision correction?

❑..have family members in need of eyecare?

❑..have problems driving at night?

❑..have East/West morning or evening commute?

❑..have dissatisfaction or frustration with your vision?

Explain: ____

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
(Please check boxes below, blank responses will be interpreted as no)

	Relationship (Mother's or Father's side)
Blindness	❑__________________________
Cataracts	❑__________________________
Corneal Problems	❑__________________________
Diabetes	❑__________________________
Glaucoma	❑__________________________
Heart Disease	❑__________________________
Lazy Eye	❑__________________________
Macular Degeneration	❑__________________________
Retinal Problems	❑__________________________

Computer Vision Questionnaire

Please check the box if you experience any of the following symptoms while working at a computer:

❑..headaches during or after working at computer

❑..overall bodily fatigue or tiredness

❑..burning eyes

❑..distance vision is blurry when looking up from the computer

❑..dry, tired, or sore eyes

❑..squinting helps when looking at the computer

❑..neck, shoulders, or back pain

❑..double vision

❑..letters on screen run together

❑..driving/night vision is worse after computer use

❑..“halos” appear around objects on screen

❑..need to interrupt work frequently to rest eyes

At Family EyeCare Center our commitment is to:

- ***Contribute to a lifetime of healthy vision***
- ***Provide each patient with the highest quality of vision care***
- ***Inspire confidence through patient education***
- ***Remain at the forefront of our profession***
- ***Offer the latest eye care technology, professional services, and products***

The visual needs and wellness of each patient will always be our first priority.