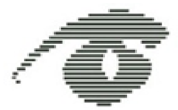

PATIENT HISTORY

SPECTACLE LENS HISTORY

Do you use a computer? ☐ Yes ☐ No How many hours/day? ___ Distance from Computer? ___
Do you drive? ☐ Yes ☐ No Mileage to work each way? ___
Do you have glare problems? ☐ Yes ☐ No
Do you have visual difficulty when driving? ☐ Yes ☐ No
Do you have problems with night vision? ☐ Yes ☐ No
Do you currently wear glasses? ☐ Yes ☐ No Since____________

What glasses do you own? (check all that apply)

☐ Back up pair
☐ Bifocals
☐ Distance
☐ Progressive lens
☐ Reading
☐ Safety Glasses
☐ Single Vision
☐ Sports Glasses
☐ Sunglasses
☐Trifocals
Other:

Check Any that apply:

☐ Allergic to nickel (frames)
☐ I do not want to wear glasses
☐ Incorrect prescription
☐ Need spare glasses
☐ Need sunglasses with UV
☐ Problems with current glasses
☐ Problems with glare
☐ Problems with night vision
☐ Special eyewear needs

Have you had trouble in the past with glasses? ☐ Yes ☐No
Do you wear sunglasses? ☐ Yes ☐No
Are your sunglasses your current prescription? ☐ Yes ☐No

SPECIAL EYEWEAR NEEDS

☐ Computer(special prescriptions, special anti-glare tints/coatings) ☐ Sports/Hobbies(racquet sports, motorcycle)
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (gardening, woodworking, welding)

CONTACT LENS HISTORY

What brand of contacts do you wear? ____________________
How old are your current contacts? ____________________
How often do you replace them? ____________________
What solution do you use for soaking? ____________________
What is your typical wearing schedule? ____________________

Check any that apply

☐ I do not want to wear contacts
☐ Incorrect prescription
☐ Interested in non-surgical correction
☐ Interested in refractive laser surgery
☐ Need spare contacts
☐ Problems with current contacts
☐ Would like to change my eye color

SOCIAL HISTORY

Do you use nutritional supplements (vitamins, etc.)? ☐ Yes No
Do you engage in regular exercise? ☐ Yes No
Do you drink alcohol? ☐ Yes No
If yes, how much/often: ☐ Occasional 1 per day ☐ 2-3/day ☐ 4+/day
Do you smoke? ☐ Yes No
If yes, how much/often: ☐ Occasional 1/2 pack/day ☐ 1 pack/day ☐ 1+ pack
Smoking Status ____
Method of Tobacco Intake: ☐ Smoking ☐ Chewing

Do you use illegal drugs: ☐ Yes ☐ No

Hobbies/Interests: ____

PATIENT HISTORY

FAMILY HISTORY (check all that apply)

Allergies (please list)

____

- ☐ Blindness
- ☐ Diabetes
- ☐ Eye turn/lazy eye
- ☐ Glaucoma
- ☐ Hypertension
- ☐ Macular degeneration
- ☐ None

GENERAL MEDICAL HISTORY (please answer appropriately)

When (approx.) was your last eye exam?

Primary care physician name: _______________

Primary care physician phone: _______________

Please list all eye conditions you have experienced:

____

Surgeries: __________________

Do you have any of the following?

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ High cholesterol
- ☐ HIV
- ☐ Hypertension (high blood pressure)
- ☐ Migraines/headaches
- ☐ Multiple sclerosis (MS)

Other: ______________

REFERRAL INFORMATION

Why did you visit us?

- ☐ Referred by your doctor
- ☐ Visited our website
- ☐ Found us on social media
- ☐ Referred directly

Keep in touch

Facebook email ____________

@Twitter handle ____________

QUESTIONS AND NOTES

Do you have a question? Concern? We want to know.