Name: _____ D.O.B: _____ Date: _____ Patient # _____

VISION HISTORY:

Month/year of your last eye exam? _____ by Dr._____

Glasses: Have you ever worn glasses? ○ No ○ Yes ○ for distance ○ reading / computer ○ for both distance & near

What kind of glasses do you wear? ○ Single Vision ○ Bifocals ○ No-Line ○ ***Sports Glasses***

Contacts: Do you currently wear contacts? ○ No ○ Yes What type? _____

Do you need to update your contact lens Rx today? _____ (Remember Rx is only good for ONE year)

Have you had problems wearing contacts? ○ No ○ Yes Describe _____

Are you interested in trying contacts? ○ Yes ○ No Have you been told you cannot wear contacts? ○ Yes ○ No

HEALTH HISTORY:

Please answer for ALL CONDITIONS *as they apply to you* and if there is family history.

	Patient	Family			Patient	Family
ADD or ADHD	○ Yes-Pt	○ Yes-Family	Neurological Disorder		○ Yes-Pt	○ Yes-Family
Allergies	○ Yes-Pt	○ Yes-Family	Seizure Disorders		○ Yes-Pt	○ Yes-Family
Autism	○ Yes-Pt	○ Yes-Family	STD (Sexually Transmit Disease)		○ Yes-Pt	○ Yes-Family
Cancer	○ Yes-Pt	○ Yes-Family	Thyroid		○ Yes-Pt	○ Yes-Family
Cerebral Palsy	○ Yes-Pt	○ Yes-Family	Blindness		○ Yes-Pt	○ Yes-Family
Developmental Delays	○ Yes-Pt	○ Yes-Family	Cataracts		○ Yes-Pt	○ Yes-Family
Diabetes - **Type 1**	○ Yes-Pt	○ Yes-Family	Color "blind"		○ Yes-Pt	○ Yes-Family
Diabetes - **Type 2**	○ Yes-Pt	○ Yes-Family	Dry Eyes		○ Yes-Pt	○ Yes-Family
Drug sensitive	○ Yes-Pt	○ Yes-Family	Eye Turn/Strabismus		○ Yes-Pt	○ Yes-Family
Dyslexia	○ Yes-Pt	○ Yes-Family	Eyestrain		○ Yes-Pt	○ Yes-Family
Elevated Cholesterol	○ Yes-Pt	○ Yes-Family	Flashing lights		○ Yes-Pt	○ Yes-Family
Gastrointestinal Disease	○ Yes-Pt	○ Yes-Family	Floaters/Spots		○ Yes-Pt	○ Yes-Family
Glandular Disorder	○ Yes-Pt	○ Yes-Family	Glaucoma		○ Yes-Pt	○ Yes-Family
Head trauma	○ Yes-Pt	○ Yes-Family	Lazy eye /Ambylopia		○ Yes-Pt	○ Yes-Family
Headache/Migraine	○ Yes-Pt	○ Yes-Family	Light sensitive		○ Yes-Pt	○ Yes-Family
Heart problem	○ Yes-Pt	○ Yes-Family	Macular degeneration	○ No-Pt	○ Yes-Pt	○ Yes-Family
High blood Pressure	○ Yes-Pt	○ Yes-Family	Retinal detachment	○ No-Pt	○ Yes-Pt	○ Yes-Family
Learning Disabilities	○ Yes-Pt	○ Yes-Family	Eye surgery or injury _____			
Muscular Disorder	○ Yes-Pt	○ Yes-Family	Other _____			

PRIMARY OR FAMILY DOCTOR:

Name & number of your Primary Doctor? ○ No ○ Yes **Name / Number** _____ City: _____

Date of your last physical _____ **Are you taking any medications regularly?** ○ **Yes** ○ **No**

Please list your medications and what conditions they are for:

1 _____ for _____

2 _____ for _____

3 _____ for _____

4 _____ for _____

5 _____ for _____

Please rate your general state of health? *(Circle one)* ○ **Excellent** ○ **Good** ○ **Fair** ○ **Poor**

Please fill in BOTH SIDES of this form as completely as possible.

OCCUPATION: **What kind of work do you do?** _____

What activities do you do at work: (Circle all that apply) ○ driving ○ computers ○ accounting ○ writing/editing ○ monitor equipment other: _____

Do you use a computer on your job or at home? ..... ○ Yes ○ No # hours daily _____

When on the computer, do your eyes get ..... ○ red ○ dry ○ ache ○ sore

Do you feel pain or discomfort in your.....○ neck ○ back ○ shoulders

Do letters ever seem to "swim"? ..... ○ Yes ○ No Does office lighting bother you? ○ Yes ○ No

Do reflections and glare bother you?..... ○ Yes ○ No Is it hard to proofread or find errors? ○ Yes ○ No

PAIN OR DISCOMFORT: **Do you experience ANY of the following? (*Check ALL that apply*)**

☐ Headaches ☐ Sensitivity to light? ☐ Stationary objects seem to be moving?

☐ Any pain? **Where** _____ **When** _____

☐ Eyestrain ☐ Letters blur as you read ☐ Occasionally see double ☐ Any blind spots

☐ Eyes red or watery ☐ Eyes dry ☐ Pulling sensation near eyes

☐ Get sleepy ☐ Lose your place often

☐ Avoid certain tasks **What** _____ **When** _____

☐ Takes more and more effort to see clearly as the day wears on?

☐ Avoid reading after work, but read on weekends? How long can you read? _____

☐ "Hunch" closer to your work as the day wears on?

☐ Do street signs seem to blur as you drive home from work? ○ Yes ○ No

☐ Is it ever difficult to bring print or objects to clear focus? **When**_____

☐ **NONE OF THE ABOVE**

RECREATION AND LEISURE*:* **What recreational activities do you enjoy? (*Circle ALL that apply)***

Read racquetball soccer tennis golf baseball basketball swim camp

Sew play cards flying video games musical instrument other _____

Is viewing TV ever uncomfortable? Please describe: _____

Do you recline while viewing? ○ Yes ○ No Do wear your glasses to watch TV? ○ Yes ○ No

Do you often play video games? ○ Yes ○ No How often ○ 1-2 hours ○ 3-6 hours ○ more

EYEWEAR*:* **What are you doing to protect your eyes . . .?**

from UV exposure? _____

while playing sports? _____

Are you interested in lenses that "**TRANSITION**" **or darken in sunlight?** ○ Yes ○ No

Do your glasses have an anti-reflective/anti-glare/anti-scratch lens such as **CRIZAL Sapphire*?*** ○ Yes ○ No

Signed ⊗ _____ **Date →** _____

If not the patient, PRINT YOUR NAME: _____ Relationship to patient: _____

Modified 6/17/2014

THANK YOU VERY MUCH FOR YOUR TIME AND EFFORT IN FILLING OUT OUR FORMS.