

Name _____
Last First

Today's Date _____

Address _____ City _____ State _____ Zip _____

Married _____ Single _____ Other _____ Male _____ Female _____

Primary Medical Insurance: _____

Vision Insurance (if applicable): _____

Date of birth: ___/___/___ Social Security # _____

Phone # (H) _____ (W) _____ (Mobile) _____

E-mail Address: _____ Occupation: _____

Were you referred to us? _____ If yes, by whom? _____

When was your last eye exam? _____ By whom or where? _____

If you wear contact lenses, what is the prescription and the brand? _____

Are you interested in wearing contact lenses? _____

Please list any medications you are taking (include birth control): _____

Please list any medical conditions you may have: _____

List any allergies: _____

Have you ever noticed or experienced? (Circle all that apply):

Flashes of light Floaters Double Vision Redness in Eyes Burning

Tearing Eye injury Eye Discharge Blurring Itching in Eyes

Surgery? (List) _____

Indicate if you or any family member has the following, indicating which family member:

Glaucoma _____ Cataracts _____ Eye Turn _____

Blindness _____ Eye Disease _____ Macular Degeneration _____

Diabetes _____ Hypertension _____ Heart Disease _____

Are you interested in Laser Vision Correction? _____

What is the reason for today's visit? _____
