TODAY'S VISION

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Today's Date: ______________

Patient Information

Name ____________________
LAST FIRST MI NICKNAME

Title: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ .Dr. ☐ Male ☐ Female ☐ Date of Birth ____________

Address ____________ City ____________ State ____ Zip Code ____________

Home Phone ____________ Work Phone ____________

Cell Phone ____________ Email Address ____________

Parent's Name/Responsible Party/Spouse ____________

Patient's or Parent's Employer ____________ Occupation ____________

If Student, Name of school ____________ Grade ______

Patient's Social Security Number ____________

Have we seen other members of your family? Yes ☐ No ☐

If yes, please list names ____________

How did you find out about our office? ☐ Mailout ☐ Insurance ☐ Location ☐ Newspaper ☐ Phone book ☐ Internet ☐ Direct Referral, Name ____________

Financial Arrangements

Preferred Method of Payment Cash ☐ Check ☐ Credit Card ☐

Do you have health insurance carrier that provides vision benefits? Yes ☐ No ☐

If yes, please give name of provider ____________

Are you the: Member ☐ Spouse ☐ Dependent ☐

If not the Member, Member's name ____________ DOB ______ SSN ____________

Member's Employer ____________ Policy # / Group # ____________

Eye History

When was your last eye examination? ____________ Doctor's Name ____________

Please check any of the following conditions that apply:

Condition	You	Your Family	Condition	You	Your Family
Eye surgery	☐		Eye turn/crossed eye	☐	☐
Eye injury	☐		Glaucoma	☐	☐
Vision therapy	☐		Cataract	☐	☐
Eye disease	☐	☐	Macular degeneration	☐	☐
Blindness	☐	☐	Retinal disorders	☐	☐
Lazy eye	☐	☐			

Please check any of the following conditions that apply to you:

Frequent headaches	☐			Double vision (ever)	☐
Floaters or spots	☐			Eye strain	☐
Poor distance vision:	☐			Eyes itch, burn	☐
with glasses	☐	without glasses	☐	Eyes water	☐
Poor near vision:				Recent eye infection	☐
with glasses	☐	without glasses	☐	Sensitive to light	☐

Glasses History

Have you ever worn glasses? Yes ☐ No ☐

Do you currently wear glasses? Yes ☐ No ☐

What age were you when you first got glasses? ____________

When do you wear your glasses? ☐ All the time ☐ Reading/Near tasks only ☐ Distance only ☐ Work safety

Refractive Surgery

Have you ever had refractive surgery? Yes ☐ No ☐ If yes, what kind? ______________________

Are you interested in information on laser refractive surgery? Yes ☐ No ☐

Contact Lens History

Are you interested in contact lenses? Yes ☐ No ☐

Have you ever worn contact lenses? Yes ☐ No ☐

If yes, when were you first fit in contact lenses? (year) ______________________

Do you still currently wear contact lenses? Yes ☐ No ☐

If no, when did you stop wearing them? (year) ______________________

Type most recently worn (*circle all* that apply):

Soft / RGP / Hard	Toric (for astigmatism)
Conventional / Disposable	Bifocal / Monovision (one eye for reading)
Daily remove / Sleep in	Colors

Are you interested in trying any of the above? Please list ______________________

What lens care system you are using? ______________________

Do you have any allergies to lens care solutions? If yes, please list ______________________

Describe any problems you are having with our contact lenses: ______________________

Medical History

Please check any of the following conditions that apply:

Condition	You	Your Family	Condition	You
Diabetes	☐	☐	Sinus Problems	☐
High Blood Pressure	☐	☐	Migraine Headaches	☐
Thyroid Disease	☐	☐	AIDS/HIV	☐
Arthritis	☐	☐	Tuberculosis	☐
Heart Disease	☐	☐	STD	☐
Neurological Disorders	☐	☐	Stroke	☐
Lupus/Autoimmune Disease	☐	☐	Head Injuries/Trauma	☐
Cancer	☐	☐	Seizures	☐
Kidney Disease	☐	☐	Asthma	☐
Multiple Sclerosis	☐	☐	Pregnant	☐

Other conditions you are being treated or tested for ______________________

Do you use cigarettes/tobacco? __________ Alcohol __________? Other substance(s)? __________

List all Medications you are taking	Reason

List any Medication Allergies ______________________

Pupil Dilation

Dilating eye drops are used to temporarily enlarge your pupils. This allows the doctor a more thorough examination of your retina (back of the eye) to look for eye disease that cannot otherwise be detected. Generally the effects last about 4 hours. During this time your eyes will be extra sensitive to light and near vision may be blurred. Distance vision will be fine in most cases.

We strongly recommend that all of our patients receive this procedure. The fee for the dilated examination is $20.00. Your insurance may cover this expense.

If you choose to **decline** this procedure, please sign below.

I do NOT want the dilated examination.

X ______________________