Personal Eye Information

Do you wear Glasses? Yes No Contact Lenses? Yes No

Are you wearing them now? Yes No

Are you satisfied with your: Glasses? Yes No Contacts? Yes No Lasik? Yes No

About how many hours a day are you on the computer?_____

Are you having issues seeing near or far?_____

Do you have any specific visual needs?_____

Have you had any eye operations?_____ Date _____

Do you have any allergies? (food, medication, dust, animals, etc.)

_____

Any health or medical changes from last visit?_____

Are you taking any medications? Yes No If you answered yes please list them:

_____

Do you have any of the following symptoms?

_____ Tearing _____ Headache _____ Flashes of Light

_____ Itching _____ Red Eye _____Floaters

_____ Burning _____ Dry Eye _____ Cross Eye/Lazy Eye/Amblyopia

_____Eye Pain_____ Double Vision

Is there any other concerns you would like to discuss today?

_____

Has your address or phone number changed? Yes No If so, please complete:

Address_____

Phone number_____

Patient name please print: _____

Patient/Guardian Signature:_____________________________________Date______________