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Doctors of Optometry
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Name Mr / Mrs / Ms / Miss / Dr ______________________ Date of Birth ______________

Address ____

Telephone: Home____________ Business ______________ E-Mail Address______________

Social Security # ______________________Spouse's Name ______________________

Your Occupation ______________________Where Employed ______________________

If you are a student, name of school/college ______________________

Children's names and ages ______________________

Whom may we thank for referring you? ______________________

Primary reason for today's visit ______________________

Do you have vision insurance you intend to use for today's visit? Yes No If so, please list provider ____________

PLEASE CIRCLE THE CORRECT ANSWER TO THE FOLLOWING QUESTIONS:

Do you ever experience double vision? Yes No
Are you troubled by frequent headaches? Yes No
Associated with any particular activity? Yes No If so, please list______________
Are you presently taking any medications? Yes No If so, please list______________
____

Do you use smoke tobacco products? Yes No
Are you presently under a physician's care? Yes No If so, physician's name______________
Do you have allergies or hayfever? Yes No If so, please list______________
Do you wear UV protective sunglasses regularly? Yes No
Do you have particular difficulty driving at night? Yes No
Is the lighting at your place of employment comfortable? Yes No
Do you use a computer? Yes No If so, how many hours per day?____________

OPTICAL HISTORY:

Date of last eye exam______________ By Doctor______________Location______________

Do you wear glasses? Yes No If so, when? Constant Distance Near/Reading
If so, what is the age of your present glasses?________
Are there times when you'd prefer not to wear glasses? Yes No If so, when?______________

Are you interested in contact lenses? Yes No
Do you currently wear contact lenses? Yes No If so, what type? Soft RGP Hard Disposable
Hours worn each day ______________ What solutions do you use? ______________
Do your eyes become dry, itchy, or irritated when wearing contact lenses? Yes No
Do your contacts become less comfortable as the day progresses? Yes No

Have you had laser or vision corrective surgery? Yes No If so, when?________ Doctor __________
If not, are you interested in learning more about laser vision correction? Yes No

PLEASE CHECK THE FOLLOWING DISORDERS YOU HAVE EVER HAD:

___ Heart Trouble	___ High Cholesterol	___ Serious Head or Eye Injury	___ High Blood Pressure
___ Sinus Trouble	___ Eye Infection	___ Lung Disorder	___ Low Blood Pressure
___ Thyroid Trouble	___ Eye Disease	___ Diabetes	___ Other, please list

FAMILY HISTORY: (Please indicate which family members: brothers/sisters, parents, or grandparents)

Diabetes _________________ Glaucoma_______________________ Cataracts___________________

Blindness_________________ Lazy Eye (Amblyopia) _______________________

Thyroid problems_________________ Other eye problems __________________________

PLEASE CIRCLE ANY OF THE FOLLOWING ACTIVITIES YOU PARTICIPATE IN:

Artistic Painting	*Computer*	*Reading*	*Golf*	*Scuba diving*
Ceramics	Public Speaking	Photography	Football	Fishing
Knitting	Musical Instrument	Basketball	Swimming	Lawn care
Sewing	Stamp collecting	Baseball	Tennis	Softball
Needlepoint	Coin Collecting	Racquetball	Hockey	Bowling
Electronic	Home Workshop	Soccer	Skiing	
Model building	Other__________________________________			

IF YOU HAVE ANY QUESTIONS ABOUT ANY OF THE FOLLOWING TOPICS, PLEASE CIRCLE AND WE WILL BE GLAD TO ANSWER THEM:

Contact lenses:	Standard bifocals	Children's vision
soft	Invisible (progressive lens) bifocals	Visual training
disposable	Trifocals	Developmental vision
rigid gas permeable	Computer	Color vision
extended wear	No-glare lenses	Visual perceptual skills
tinted	Extra-thin lenses	Eye exercises
toric (astigmatic)	Safety glasses	Vision rehabilitation
monovision/bifocal	Prescription sunglasses	Low vision devices
for special occasions	Refractive surgery (laser)	Other__________________

PAYMENT POLICY

Examination fees are due at the time of service. A 50% deposit is required to order glasses or contact lenses, with the balance due at dispensing. With the exception of insurance carriers with which we are on contract, patients are expected to take care of their fees as services are provided. For all other insurances, we will provide you with a walk-out statement for you to file with your insurance carrier.

For your convenience, payment may be made in the form of cash, check, Visa, MasterCard, Discover, or American express.

SIGNATURE ____ DATE___________________