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Name Mr / Mrs / Ms / Miss / Dr _____ Date of Birth _____

Address _____

Telephone Home: _____ Work: _____ Cell: _____

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 _____

Do you have **major medical** insurance? Yes No

If so, please list provider _____

PLEASE CIRCLE THE 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 _____

Are you presently taking any medications? Yes No

If so, please list _____

Are you presently under a physician's care? Yes No

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

Do you use a computer? Yes No

OPTICAL HISTORY:

Date of last eye exam _____ 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? _____

Where did you purchase them? _____

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 contact lenses become less comfortable as the day progresses? Yes No

Have you had laser or vision corrective surgery? Yes No

If so, when? _____ Doctor _____

Are you interested in learning more about laser vision correction? Yes No

