So that we can help you best, please fill out both pages legibly and completely.

Legal Name: _____
First MI Last

Nickname: (Please call me): _____

Reason(s) for your visit today?

- ❑ Comprehensive vision and eye health examination
- ❑ New Contact Lens Evaluation
- ❑ Contact lens progress evaluation
- ❑ Ocular health evaluation
- ❑ New glasses
- ❑ New contact lenses
- ❑ Corneal Refractive Therapy (CRT) / Orthokeratology Evaluation: Gently reshapes your cornea and allows you to be free of daytime contact lenses or eyeglasses without undergoing surgery.
- ❑ School referral
- ❑ Failed DMV eye test
- ❑ Laser vision (LASIK) correction evaluation
- ❑ Other_____

When was your last comprehensive eye examination? ¨

- ❑ Never
- ❑ Less than 1 year
- ❑ 1 year
- ❑ 2 years
- ❑ 3+ years

Do you wear glasses? Yes No

If yes, do you wear them:

- ❑ Full time
- ❑ Part time
- ❑ Seldom

For what purpose were they prescribed?

- ❑ General use
- ❑ Distance Only
- ❑ Near Only
- ❑ Computer Use
- ❑ Occupational
- ❑ Safety
- ❑ Sport
- ❑ Sunglasses

Describe your computer use:

- ❑ Extensive (5+ hrs/day)
- ❑ Moderate (1-4 hrs/day)
- ❑ Low (Less than 1 hr/day)
- ❑ Seldom
- ❑ Never

Eye Surgeries:

- ❑ None
- ❑ LASIK
- ❑ PRK
- ❑ RK
- ❑ Intacs™
- ❑ Cataract
- ❑ Retinal
- ❑ Glaucoma
- ❑ Eyelid
- ❑ Other _____

Chief complaint(s):

- ❑ None
- ❑ Distance Blur
- ❑ Near Blur
- ❑ Intermediate Blur
- ❑ Computer blur & eye fatigue
- ❑ Trouble reading
- ❑ Headaches
- ❑ Eyestrain
- ❑ Eyes burn
- ❑ Eyes water
- ❑ Pressure around eyes
- ❑ Eyes feel sandy/gritty
- ❑ Eye pain
- ❑ Eyes red
- ❑ Floaters / Flashes
- ❑ Double vision
- ❑ Decreased side vision
- ❑ Light sensitivity
- ❑ Eyes itch
- ❑ Other (describe)

_____

Contact Lenses History

- ❑ I've never worn contacts
- ❑ I wear contacts daily
- ❑ I wear contacts occasionally
- ❑ I wear weekends only
- ❑ I wear socially only
- ❑ I used to wear contacts
- ❑ Are you interested in contact lenses? Yes No

Are your contacts lenses?:

- ❑ Soft
- ❑ Rigid
- ❑ Astigmatism
- ❑ Replaced daily
- ❑ Disposable
- ❑ Nondisposable
- ❑ Monovision
- ❑ Bifocal / Multifocal
- ❑ Eye color changing
- ❑ Other _____

Lifestyles Contact Lens Questionnaire

- ❑ If soft disposable, which brand and lens power are you wearing? _____
- ❑ Rate on a scale of 1-10, with 10 being excellent
  - Lens Comfort: Right____ Left____
  - Distance Vision: Right____ Left____
  - Near Vision: Right____ Left____
- ❑ What solutions do you use?_____
- ❑ Lenses are worn _____hours per day
- ❑ Lenses are worn _____days per week
- ❑ Lenses are worn _____nights in a row without removing
- ❑ Lenses are slept with regularly
- ❑ How old is your current pair of lenses? _____
- ❑ How frequently do you replace a pair? _____

- ❑ Are you interested in wearing contact lenses?
- ❑ Are you interested in wearing contact lenses for sports, just on weekends, or so[illegible]

Family Medical History

- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Stroke
- ❑ Thyroid
- ❑ Weight loss/gain
- ❑ Other disease _____

Family Ocular History

- ❑ Blindness
- ❑ Cataracts
- ❑ Cataract surgery
- ❑ Lazy eye
- ❑ Macular degeneration
- ❑ Glaucoma
- ❑ Retinal disease
- ❑ Other disease_____

_____

_____

List any prescription or nonprescription medications you take:

_____

_____

_____

_____

_____

Medication allergies

None Penicillin Sulfa Codeine

Other _____

Physician Name_____

First Last

Address _____

Telephone _____

_____

Have you had a serious eye injury?

Describe _____

_____

_____

_____

So that we can get to know you better, what hobbies, sports, or other activities do you enjoy?

_____

_____

_____

Personal Medical History

Since many general medical conditions can affect the eye, we need to know any medical conditions you have and medications you take:

Medical History

- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Gastrointestinal
- ❑ Headaches
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Neurologic
- ❑ Respiratory
- ❑ Skin disorder
- ❑ Other disease_____

Ocular History

- ❑ Blindness
- ❑ Blurred vision
- ❑ Cataracts
- ❑ Cataract surgery
- ❑ Lazy eye
- ❑ Macular degeneration
- ❑ Glaucoma
- ❑ Retinal disease
- ❑ Other Disease _____

Dry Eye and Allergy

- ❑ Burning
- ❑ Contact lens discomfort
- ❑ Fluctuating vision
- ❑ Foreign body sensation
- ❑ Itching
- ❑ Light sensitivity
- ❑ Redness
- ❑ Sandy/Gritty feeling
- ❑ Tearing

Lifestyles Eyewear Questionnaire

- ❑ Are your lenses reflection-free?
- ❑ Do your lenses reduce glare?
- ❑ Do your lenses change color?
- ❑ Do you want thin lenses?
- ❑ Do you want lightweight lenses?
- ❑ Do you have prescription sunglasses?
- ❑ Are your sunglasses polarized for greater comfort?
- ❑ Do you have computer glasses to reduce fatigue?
- ❑ Do you have sport or safety glasses?
- ❑ Do you have visual difficulty when driving?
- ❑ Do you have problems with night vision?