PATIENT NAME:____ **DOB:**______________________ **DATE:**_________________

PERSONAL EYE INFORMATION:

We would like to thank the person who referred you to our office: How did you hear about us? (friend, co-worker, family, google, insurance, etc.)____

•So we may better serve your vision needs, please complete the questions below regarding your visit to our office:

Date of last eye exam: ____________________________________

Do you wear glasses? □ **Yes** □ **No** Full time__ Part time__ Near only__ Driving only__ Computer__

Do you wear contact lenses? □**Yes** □ **No** **Brand?**____________________ **Brand of solution?**___________________

Do you sleep in your contacts? □ **Yes** □ **No** **If yes, how often do you remove?**________________

How often do you dispose of your contact lenses?_____________________________________

Your reason(s) for visiting our office today: (Please check all that apply)

GENERAL CHECK UP	HEADACHES	WANT CONTACT LENSES
BLURRED VISION FAR	LIGHT SENSITIVITY	LOST OR BROKE GLASSES
BLURRED VISION NEAR	EYES WATER	EYES ITCH
EYES FEEL DRY	FLASHES OF LIGHT	PAIN IN EYES
DOUBLE VISION	FLOATING SPOTS IN EYES	NIGHT VISION PROBLEMS
LOSS OF VISION	REDNESS	TIRED EYES
STYES/ CHALAZION	OTHER:	

DIABETICS ONLY:

Primary Care Physician:_____________________________________ Phone #____________________________________

Are you □ Type 1 □ Type 2 □ Gestational □ Prediabetes

How long have you been diabetic?__________ Results of last Finger-Stick:__________________ □ Unknown

Last A1C: (3 month blood test your doctor does) ___________ □ Unknown

Do you feel like your diabetes is under control? □ YES □ NO

All diabetics will be dilated at every visit.

MEDICATIONS: □ **N/A** ____

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DRUG ALLERGIES: □ **N/A** ____

MAJOR SURGERIES: □ **N/A** ____

Dilation informed consent: **Dilation is recommended every other year, even in healthy eyes. First visit to our office. Dilation may be required more frequently by your eye doctor for many ocular and systemic conditions. Many serious and sometimes vision threatening conditions cannot accurately diagnosed or detected without dilation. Dilation will make you light sensitive, and will make your distance and near vision blurry (mostly near). Driving is usually safe when dilated, and the patient assumes all risks of operating a motor vehicle, as well as any other visually demanding tasks, while dilated.**

DO YOU WISH TO BE DILATED TODAY? □YES □NO □IF NECESSARY INITIAL________

Do you smoke/ chew/ vape? □ Yes □ No Do you drink alcohol? □ Yes □ No Do you use illegal drugs? □ Yes □ No