Welcome to Our Office: Please help us get to know you!

Name:_____ Parent's Name, if child_____Date:_____

Occupation:_____ Work phone_____ cell phone_____

Email address:_____

1. **What Are Your Vision Concerns Today**?_____

2. **Do you currently wear**: (please circle all that apply)

Glasses:	Yes	No	For constant wear	For Distance Only	For Reading Only
Sunglasses:	Prescription	Non-Prescription			
Contact Lenses	Yes	No	Every Day	Occasionally	Days & Some Nights

Type of contacts: RGP Soft Daily Disposable Monthly Disposeable

3. **How old is the pair of glasses you are <u>currently</u> wearing**?_____ **How old are the contacts**?_____

4. **Please circle if you have had or been told you have any of the following in the past**:

Cataracts Glaucoma Diabetes Lazy Eye Macular Degeneration

5. **Have you ever had any eye surgery? Y/N** Reason:_____

6. **When was your last <u>eye</u> exam**?_____

7. **Do you have any blood relatives with any of the following**:

Cataracts Glaucoma Diabetes Lazy Eye Macular Degeneration Don't Know

8.**<u>Current Medications/vitamin/supplements</u>**:(front desk will gladly photocopy for you):

_____

_____

(continue on back if needed**)

9. **When was your last <u>medical</u> exam**?_____ **Who/Where is your family Doctor**?_____

10. **Do You Have Seasonal Allergies**: Y/N **Food Allergies**? Y/N **Medicine Allergies**?_____

11. **Do you Smoke?** Y/N

12. **Do you work at or frequently use a computer**? Y/N How many hours per day?_____

13. **Are you interested in any of the following**:

New Glasses Contact Lenses Laser Surgery Arranging an appt for a friend/family