Reason for your visit Today?____________________

Any questions or problems with your current glasses you would like to discuss with the doctor or staff today? ____________________

What type of prescription glasses do you currently use?

○General ○Computer ○Sunglasses ○Driving ○Readers ○OTC

Please indicate how often you experience each vision problem:

	Frequently	Occasionally	Seldom/Never
Dry Eyes/Itchy Eyes	○	○	○
Glare while driving at night?	○	○	○
Glare in sunlight or bright lights?	○	○	○
Tired eyes when working on a computer?	○	○	○
Difficulty reading printed material?	○	○	○
Difficulty seeing the television cleary?	○	○	○
Discomfort wearing glasses?	○	○	○
Neck or back strain while working at a computer?	○	○	○
Inconvenience switching between regular glasses and sunglasses?	○	○	○

Estimate how many hours you spend daily on the following activities:

On a computer?	○0	○2	○4	○6	○8+
Reading printed material?	○0	○2	○4	○6	○8+
Watching television?	○0	○2	○4	○6	○8+
Outdoors?	○0	○2	○4	○6	○8+
Driving a vehicle?	○0	○2	○4	○6	○8+

What sporting or outdoor activities do you participate in?____________________

What hobbies are you actively involved in? ____________________

Are you interested in wearing Contacts? ○Yes ○No

Contact Lens patients, please complete the following:

Are you satisfied with your vision for distance and near tasks?	○Yes	○No
Are you satisfied with the comfort?	○Yes	○No
Do you have a pair of glasses with your current Rx?	○Yes	○No
Are you interested in Laser Vision Correction ?	○Yes	○No

Personal & Family Medical History

	Self		Family			Self		Family	
Allergies	○Yes	○No	○Yes	○No	Migranes	○Yes	○No	○Yes	○No
Arthritis	○Yes	○No	○Yes	○No	Stroke	○Yes	○No	○Yes	○No
Asthma/COPD	○Yes	○No	○Yes	○No	Thyroid Disease	○Yes	○No	○Yes	○No
Cancer	○Yes	○No	○Yes	○No		○Yes	○No	○Yes	○No
Diabetes	○Yes	○No	○Yes	○No	Cataracts	○Yes	○No	○Yes	○No
Elevated Cholesterol	○Yes	○No	○Yes	○No	Eye Injury	○Yes	○No	○Yes	○No
Heart Attack	○Yes	○No	○Yes	○No	Eye Surgery	○Yes	○No	○Yes	○No
Heart Disease	○Yes	○No	○Yes	○No	Glaucoma	○Yes	○No	○Yes	○No
High Blood Pressure	○Yes	○No	○Yes	○No	Macular Degeneration	○Yes	○No	○Yes	○No

Name of current Medications, Rx & OTC:

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Known Drug Allergies ____________________