PLEASE READ & COMPLETE ALL QUESTIONS

All Information is Strictly Confidential.

Name ____Date of Birth____
Preferred Name ____________________________________SS# if using insurance ________________________________
Address____
Phone #______________________________________E-mail ____

Thank you for choosing The Eye Center! Please choose your primary reason for today's visit:

- ○ Annual eye exam
- ○ Annual exam for contact lenses
- ○ Diabetic eye exam
- ○ Eye Injury *(please explain)* ______________________________________
  ____
- ○ Follow up/Testing ____

Additional concerns____

When was your last eye exam? _____________________________________

Do you wear glasses ☐Yes ☐No Are you interested in new glasses ☐Yes ☐No
How old are your current glasses ___________________________________

Contact lens patients: Answer ALL questions clearly
What type of contacts? ☐Soft ☐RGP ☐Ortho K ☐Semi-scleral ☐New wearer
What brand of contacts are you currently in? ____
On a scale of 1 -10 (10 being the best) how would you rate the comfort of your lenses? __________________________
How often do you change your contact lenses *(daily, weekly, monthly)*? _______________________________________
How many nights a week do you sleep in your lenses? ____
What brand of solution do you prefer? ____
Additional comments about your contacts: ____

Diabetic patients:
Current A1C ________________ Current Blood Sugar _________________ Years Diabetic _____________
Diabetes Mellitus: Type 1 Type 2 Pre-diabetic Gestational
Name of physician who prescribes your diabetic medication ____
Physician's Tel # ___________________________________ Fax# ____

Glaucoma patients:
Which eyes are affected? _______________________ When were you diagnosed? ______________________
What drops do you take, and when do you take them? ____
List any side effects associated with your drops: ____

Migraine patients: Please answer only if diagnosed by physician
Prescribing Physician _______________________________________ Are your migraines Tolerable OR Intolerable
Where are your migraines located? Forehead / Temple / Back of head / Jaw area / Eye area
How often? _____________________________ How many years? _______________________________________
Circle all of the associated symptoms: loss of vision / nausea / fainting / floaters / aura or flickering lights
List all at home and/or prescribed migraine management and how long you have been taking them:
____

Medical History:

List ALL medications (eye and non-eye related including over the counter medications):

____

____

List ALL medical conditions (whether taking medication or not):

____

____

List ALL eye injuries, eye surgeries, and any medical diagnoses (macular degeneration, detachments, etc) & when they occurred:

____

Do you have **Sleep Apnea**? ☐ Yes ☐ No

If yes, do you sleep with a CPAP machine?☐ Yes ☐ No

Social History:

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/ how long: ____________________

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/ how long: ____________________

Hobbies and Activities:

☐Computers ☐Sports________________ ☐Reading ☐Biking ☐Fishing ☐Sewing

Other ____

What kind of work do you do? ____

Immediate Family History (Check members who apply):

	Father	*Mother*	*Brother*	*Sister*	*Son*	*Daughter*
Cancer						
Diabetes						
High Blood Pressure						
Thyroid Issues						
Cataracts						
Macular Degeneration						
Glaucoma						

Allergies:

List all medication allergies ____

Food allergies ____

Other ____

Do you have seasonal allergies? ☐ Yes ☐ No Are you sensitive to latex? ☐ Yes ☐ No