EYES FOR YOU

Date:_____ First Name:_____ MI:_____ Last Name:_____

Phone:(____)_____ Sex:_____ Race:_____ Age:_____ DOB:_____

Address:_____City:_____State:_____Zip:_____

Emergency Contact Name & Phone:_____

Occupation:_____ Hobbies:_____

Reason for visit:_____

List all current eye drops/products:_____ Allergies:_____

Medications:_____

Date of last eye exam:_____ Are you pregnant or nursing? Y N Do you smoke? Y N

Average digital device use:_____hours per day Pharmacy Name:_____

Pharmacy Address:_____ Pharmacy Phone:(____)_____

Check all that apply:

	Patient	List family member		Patient	List family member
Cataracts			Thyroid dysfunction		
Glaucoma			Sinusitis		
Macular Degeneration			High blood pressure		
Dry Eye			Skin disease		
Other eye disease/injury			Autoimmune disease		
Eye surgery			Arthritis		
Lazy eye			Stroke		
Headache/migraine			Cancer		
Diabetes			Contraceptives		
Heart disease			HIV/AIDS		
Allergy			Other		

Please provide details of above:_____

_____

Referred by:_____ Have you ever worn <u>contact lenses</u>? Y N <u>If yes, please continue</u>

At what age did you first wear them?_____What storage/cleaning solutions do you use? _____

What type/brand/power are you wearing?_____

On average, how many hours per day do you wear them?_____ and how many days per week?_____

On average, how long will you continue to wear one pair until they are disposed?_____

For office use: updated