Patient Update

Patient's Name: _____ Today's Date:_____/_____/_____

Occupation: _____ (for prescription purposes)

Has any of your personal info changed from last time? (ex: address, phone number, insurance, etc.) Yes_____ No_____

Which phone number do you preferred to be contacted on? Home_____ Cell_____ Work_____

Please list names of any Adults in your household:_____

Patient Questionnaire

Are you having any trouble seeing with: Near vision_____ Distance Vision_____ Intermediate/Computer Vision _____

Do you experience any eye pain? Yes_____ No_____ If so, How Often? Occasionally_____ Frequently_____ Always_____

Do your eyes sometimes: Burn_____ Ache_____ Itch_____ Water_____ Tire_____

Are you sensitive to light? Yes_____ No_____

Are you bothered by glare at night? (Particularly with driving) Yes_____ No_____

Do you work on a computer Yes_____ No_____ How long per day? 1-2 hrs_____3-4 hrs_____5-6 hrs_____ 8+ hrs_____

Are you interested in finding out if you are a candidate for contacts? Yes_____ No_____ I already wear contacts_____

Are you interested in LASIK? Yes_____ No_____ I've already had Lasik_____

Since doctor highly recommends yearly health checks, we suggest being pre-appointed for your exam next year. It is a tentative appointment set with the same doctor, around the same date and time. It can always be changed! We send you a notice in the mail to inform you of your appointment the month before it is scheduled with the day, date, and time.

Would you like to be pre-appointed for next year? Yes_____ No_____ It doesn't matter_____

For patients who wear contact lenses

Do you wear your contacts every day? Yes_____ No_____ How often do you sleep in your contacts?_____

How many hours a day do you wear your contacts? 1-3 hrs_____ 4-8 hrs_____ 9-12 hrs_____ 13-16 hrs_____ 16+ hours_____

How often do you switch to a new pair of contacts?:

1-2 weeks_____ 3-4 weeks_____ 1-2 months_____ 3-6 months_____ 6-12 months_____ 1+ years_____

What type of solution do you use? Optifree_____ Complete_____ Renu_____ Clear Care_____ Generic Brand_____ Other_____

Approximately how old are the lenses that you are currently wearing right now?_____

Do you rub/clean your lenses when you take them out? Yes_____ No_____

Medical History

Medications currently taking:_____

Medical Allergies:_____

Have **YOU** or **ANYONE BLOOD RELATED** to you have or have had any of the following?

High Blood Pressure, who?_____ **Diabetes**, who?_____ **High Cholesterol**, who?_____

Cataracts, who?_____ **Glaucoma**, who?_____ **Macular Degeneration**, who?_____

_____ _____

Signature of Party Responsible for patient Relationship to Patient