Who may we thank for referring you to us?

_____

Name:		**Today's Date:**	
Street Address:		**Home Phone:**	
City, State, Zip:		**Cell Phone:**	
Guardian/Spouse:		**Work Phone:**	
SSN#:		**Occupation:**	
Email:		**Employer:**	
Birth Date:		**If a student, grade:**	
M/F:		**School Name:**	

1. **What is the reason for today's visit? _____**
2. **Today's examination will be paid by (circle one). *PAYMENT DUE AT TIME OF SERVICE.***

   Cash Check Debit Visa MC Discover AMEX Other _____

Patient's Visual History	***Patient's Medical History***	***Family Health History***
[ ] None, Routine Exam	**[ ] Allergies**	**[ ] Blindness**
[ ] Distance Blur	**[ ] Asthma**	**[ ] Cataracts**
[ ] Near Blur	**[ ] Cancer**	**[ ] Cancer**
[ ] Light Sensitivity	**[ ] Diabetes**	**[ ] Diabetes**
[ ] Double Vision	**[ ] Drug Sensitivity**	**[ ] Glaucoma**
[ ] Occasional Vision Changes	**[ ] Heart Condition**	**Relation:**
[ ] Temporary Loss of Vision	**[ ] High Blood Pressure**	**[ ] High Blood Pressure**
[ ] See Flashing Lights	**[ ] Thyroid Condition**	**[ ] Lazy Eye**
[ ] See Occasional Floaters	**[ ] Tuberculosis**	**[ ] Poor Color Vision**
[ ] See Numerous Floaters	**[ ] Migraine Headaches**	**[ ] Turned Eye**
[ ] Eye Strain	**[ ] Blindness**	**[ ] Macular Degeneration**
[ ] Headaches	**[ ] Cataracts**	
[ ] Burning Eyes	**[ ] Poor Color Vision**	
[ ] Red Eyes	**[ ] Glaucoma**	
[ ] Itching Eyes	**[ ] Lazy Eye**	
[ ] Watering Eyes	**[ ] Turned Eye**	
[ ] Dry Eyes	**[ ] HIV (Aids)**	
[ ] Twitching Eye Lid	**[ ] Pregnant**	
[ ] Eye Injury	**[ ] Eye Surgery**	
Describe Injury:	**[ ] High Cholesterol**	

3. **Do you consider health to be: [ ] Good [ ] Fair [ ] Poor**
4. **Are you taking any medications or drugs? [ ] Yes [ ] No**
5. **If yes, then what are you taking and why: _____**

_____

6. **Are you allergic to any medications? [ ] Yes [ ] No If yes, which? _____**
7. **When was your last eye exam? _____ Where? _____**
8. **When was your last visit to a physician? _____ Physician's Name _____**
9. **Have you ever worn contacts? [ ] Yes [ ] No If yes, which type? _____**
10. **Solution Used? _____ Problems with contacts? _____**
11. **Would you like to know your contact lens options? [ ] Yes [ ] No**
12. **Would you like to know if you are a refractive surgery candidate? [ ] Yes [ ] No**