Please Print The Following Information

NAME _____

DATE OF BIRTH _____

STREET _____

CITY _____ STATE ZIP

HOME PHONE _____

OCCUPATION _____

WORK PHONE _____

PLACE OF EMPLOYMENT _____

HOBBIES _____

E-MAIL ADDRESS _____

HEALTH QUESTIONNAIRE

Please check (✓) those conditions that apply to you or a member of your family.

- ☐ cataracts
- ☐ glaucoma
- ☐ eye disease, injury or surgery
- ☐ blindness
- ☐ allergy/sinus trouble
- ☐ arthritis
- ☐ macular degeneration
- ☐ retinal detachment
- ☐ diabetes
- ☐ thyroid disorders
- ☐ kidney or liver disease
- ☐ heart disease or high blood pressure
- ☐ allergy to any medications
- ☐ do you smoke

Any Others_____

Please list any medications you are now taking _____

_____

Are you experiencing any of the following

- ☐ eyestrain
- ☐ headache
- ☐ trouble (or blur) seeing far away
- ☐ trouble (or blur) seeing close up
- ☐ spots, floaters or temporary vision loss
- ☐ glare or reflections
- ☐ double vision
- ☐ eye redness, tearing or pain
- ☐ trouble with school-work, occupation, hobbies or sports
- ☐ sensitive to lights

Additional Comments_____

Vision Insurance? _____

SS# _____

Do you have:	Yes	No
Good back up glasses	☐	☐
Good quality sunglasses	☐	☐
Safety glasses	☐	☐

would be interested in learning more about:

The newest in contact lens technology	☐	☐
Thinner, lighter lenses for my glasses	☐	☐
Laser vision correction	☐	☐
Non-surgical ways to correct my vision	☐	☐
Eye exercises to help me perform better at work, school and sports	☐	☐
I spend more than 2 hours a day on a computer	☐	☐

How did you hear about our office?

- ☐ Friend or relative. Who?
- ☐ Another health care practitioner. Who?
- ☐ Yellow pages. Which directory?
- ☐ Newspaper advertisement. Which paper?
- ☐ Radio advertisement. Which station?
- ☐ Previous patient. Who?_____
- ☐ Participating eye care plan. _____
- ☐ Other _____