Lifetime Eyecare
Vision Source!

Please take a moment to fill out the form below (front and back) so we may better serve you. THANK YOU!

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

Address: _____ Home Phone: _____

_____ Work Phone: _____

Employer or School: _____ Soc. Security #: ____ / ____ / ____

Birth Date: ____ / ____ / ____ Sex: M F (circle one) Last Eye Exam: ____ / ____ / ____

Spouse or Parent's Name: _____ Spouse or Parent's Work Phone: _____

Name of Medical Doctor: _____ Dr.'s Phone Number: _____

Last Medical Exam: ____ / ____ / ____

How will you settle your account today? ☐ Check ☐ Cash ☐ Credit Card

Is there any vision insurance we may file for you today? _____

How did you first hear about our office?

☐ Friend, Relative or Previous Patient: Who? _____

☐ Yellow Pages: Which Directory? _____ ☐ Newspaper Ad ☐ Radio Ad

☐ Civic Group or Community Event: Which? _____

Medical History

Do you have any allergies to medications? ☐ no ☐ yes if yes, which? _____

List any medications you take **(include oral contraceptives, aspirin, over the counter meds and home remedies)**:_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Check any of the following you have had or have currently: ☐ crossed eyes ☐ lazy eyes ☐ drooping lids

☐ bulging eyes ☐ glaucoma ☐ retinal disease ☐ cataracts ☐ eye infections

☐ eye injuries: _____

Are you pregnant or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is your current pair? _____

Do you wear contact lenses? ☐ no ☐ yes If yes, how old is your current pair? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Soft Disposables ☐ Soft Extended Wear

Brand: _____ Solution Used: _____ Are they comfortable? ☐ no ☐ yes

Do You.....

...always like to wear your glasses? ☐ no ☐ yes ...work at a computer for long periods? ☐ no ☐ yes

...have more than one pair of glasses? ☐ no ☐ yes ...want information on thinner, lighter lenses? ☐ no ☐ yes

...wear bifocals? ☐ no ☐ yes if yes, are you bothered by head tilting, restricted areas of vision, etc.? ☐ no ☐ yes

...spend a lot of time outdoors? ☐ no ☐ yes if yes, how many hours per week? _____

...have family members in need of eye care? ☐ no ☐ yes

Please turn this form over and complete side two*

Family History

Please note any family history (PARENTS, GRANDPARENTS, SIBLINGS, CHILDREN—living or deceased) for the following conditions:

DISEASE/CONDITION	no	yes	?	Relationship to you
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____
Retinal Disease	☐	☐	☐	_____

DISEASE/CONDITION	no	yes	?	Relationship to you
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____

Review Of Systems

Do YOU currently, or have you ever had, any problems in the following areas:

SYSTEM	no	yes	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Halos/Distorted Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Watering/Excess Tears	☐	☐	☐
Light Sensitivity/Glare	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Floaters/Flashes	☐	☐	☐
Tired Eyes	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐

SYSTEM	no	yes	?
VASCULAR/CARDIOVASCULAR			
Diabetes	☐	☐	☐
Blood Pressure High	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Bladder/Kidney/Genitals	☐	☐	☐
MUSCLES/JOINTS/BONES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
HEMATOLOGIC/LYMPHATIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
EARS/NOSE/MOUTH/THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain:

_____

_____

_____

_____

_____

Doctor's initials: _____ Date: _____