EYESITE

Name _____ Date _____ Occupation_____

Reason for exam today_____

_____

Name of Primary Care Physician_____

Referred by _____ Hobbies_____

Do you wear glasses? **YES NO** Age of current prescription _____
(*if yes please bring to appointment)*

Do you wear contact lenses? **YES NO** Are you interested in trying contact lenses? **YES NO**
(if yes please wear to appointment)

Do you smoke? **YES NO**

Do you have allergies? **YES NO** If yes, please list _____

Are you allergic to any medications? **YES NO** If yes, please list _____

MEDICATIONS	REASON FOR TAKING

**Please include eye drops, over the counter medication and nutritional supplements*

Please circle to denote any health problems that you have had in the following areas:

Cataracts YES NO

Glaucoma YES NO

Refractive Surgery YES NO

Thyroid Dysfunction YES NO

Diabetes YES NO

Macular Degeneration YES NO

Retinal Detachment YES NO

Strabismus YES NO

Cancer YES NO

Hypertension YES NO

Does anyone in your immediate family have:

Glaucoma YES NO

Macular Degeneration YES NO

Keratoconus YES NO

Blindness (of any kind) **YES NO**

Payment is expected when services are rendered and before glasses or contact lenses are ordered.

Do you have insurance? ☐ Yes ☐ No If yes, please complete an Insurance Information Sheet.

Do you have medical Insurance? ☐ Yes ☐ No If yes, please complete an Insurance Information Sheet.

Please bring your Insurance and ID cards to your appointment