Today's Date _____

First Name	MI	Last Name	Sex	Birthdate	Age

Please update the following information, or check box if unchanged from last visit: ☐

Home Address	City	State	Zip	Daytime Phone	Cell Phone	Text OK?
						☐

Occupation	Employer	Preferred e-mail address

RETURNING PATIENTS: PLEASE UPDATE BELOW

Do you currently experience any of the following symptoms or conditions:

	Yes	No	Office use only			Yes	No	Office use only	
Migraines with aura	☐	☐	G43.109	V	Glaucoma	☐	☐	H40.11x0	EVPG
Migraines without aura	☐	☐	G43.009	V	Amblyopia ("lazy eye")	☐	☐	H53.02*	V
Floaters in vision	☐	☐	H43.393	EP	Macular Degeneration	☐	☐	H35.31	EVP
Flashes in vision	☐	☐	H53.8	V	Multiple Sclerosis	☐	☐	G35	V
Visual distortions	☐	☐	H53.19	EV	Lupus	☐	☐	M32.10	V
Blind spot area	☐	☐	H53.42*	V					
Central blind spot	☐	☐	H53.41*	V					
Visual discomfort	☐	☐	H53.143	V				* = 1 right, 2 left, 3 bilat.	
Eyestrain	☐	☐	H53.143	V					
Light sensitivity	☐	☐	H53.143	V					
Double vision	☐	☐	H53.2	V					
Glare sensitivity	☐	☐	H53.71	V					
Other visual disturbance	☐	☐	H53.8	V					
Sudden visual loss	☐	☐	H53.13*	EV					

List any changes to your eyes or vision since last visit: _____

List any current significant illnesses or medical conditions: _____

List any changes in family eye or medical history since last visit: _____

List your current medications: _____

Do you have medication allergies? ☐ No known allergies ☐ Yes Please list:

_____

Contact lens wearers only. Please fill out the following information:

Any changes to contact lens wear? _____ Average number of days per week wearing contacts: _____

Average wearing time per day (in hours): _____ Contact lens solution brand: _____

If disposable lenses, frequency of disposal: _____ Age of current pair of contact lenses: _____

If not currently wearing contact lenses, how long since the last time worn? _____