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

Reason for today's visit / Chief complaint:_____

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

Circle any systemic disorders (please explain below) Allergic Cardiovascular Fever/Fatigue/Weight loss Ear-Nose-Throat Endocrine Gastrointestinal Genitourinary Blood/Lymphatic Immunologic Skin Musculoskeletal Neurologic Psychiatric Respiratory

_____

_____

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

List your current medications:_____

_____

Do you have medication allergies? [] No known allergies [] Yes Please list:_____

Check if you currently or in the past have had any of the following symptoms, and when:

	Yes	No	When	Office use only
Migraine headaches	[]	[]	_____	G43.109 V
Floaters in vision	[]	[]	_____	H43.393 P
Flashes in vision	[]	[]	_____	H53.19 V
Glare sensitivity	[]	[]	_____	H53.71 V
Eye strain	[]	[]	_____	H53.143 V
Light sensitivity	[]	[]	_____	H53.19 V
Double vision	[]	[]	_____	H53.2 V
Routine headaches	[]	[]	_____	--

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?_____