

Today's Date _____

First Name	MI	Last Name	Sex	Birthdate	Age
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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 if you have any of the following: Hypertension Type 1 Diabetes Type 2 Diabetes High cholesterol levels

List any other significant illnesses or medical conditions: _____

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
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Floaters in vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes in vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye strain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Routine headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____

Office use only
G43.109 V
H43.393 P
H53.19 V
H53.71 V
H53.143 V
H53.19 V
H53.2 V
EMEC 92250-52 Z13.5 E10.9 / 92250-52 Z13.5 E11.9

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? _____