ABOUT YOU

Full Name Mr. Mrs. Miss Ms. Dr. Prof.

____

Nickname ______________ Gender

DOB ____/____/____

Race ______________________________

Preferred Language ______________________

Approx. Height & Weight ____ ft ____ in ______ lbs

Do you use tobacco products?
- ☐ Y → Type __________ Frequency __________
- ☐ N
- ☐ Not anymore

Do you drink alcohol?
- ☐ Y → ☐ Minimal ☐ Moderate ☐ Excessive
- ☐ N
- ☐ Not anymore

How did you hear about us? ______________________

CONTACT

____

____

____

____

WORK DEMANDS

Occupation ______________________________

Employer ______________________________

Hours spent on computer per day:

☐ 0-3 ☐ 3-6 ☐ 6-9 ☐ 9+

Special visual demands for work:

- ☐ Computer Lenses
- ☐ Safety Glasses
- ☐ Extra magnification
- ☐ Other __________

YOUR SYMPTOMS

Please mark if you are experiencing any of the following **comfort issues:**

- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Watering
- ☐ Soreness/Irritation
- ☐ Discharge
- ☐ Dryness/Grittiness
- ☐ Pain

HOBBIES

- ☐ Reading/ Writing
- ☐ Golf
- ☐ Swimming
- ☐ Cycling
- ☐ Fishing/ Boating
- ☐ Travel
- ☐ Knitting/ Sewing
- ☐ Motorcycles

Other ______________________________

EYE HEALTH HISTORY

When was your last **eye exam?** ______________ Doctor ______________________

When was your last **physical**? ______________ Doctor ______________________

Please mark if you have ever been diagnosed with:

- ☐ Cataract
- ☐ Diabetic Retinopathy
- ☐ Dry Eye
- ☐ Eye Infection/Inflammation/Allergy
- ☐ Glaucoma
- ☐ Iritis or Uveitis
- ☐ Keratoconus/Other Corneal Disorder
- ☐ Macular Degeneration
- ☐ Nevus (Freckle) of the Eye
- ☐ Retinal Defects or Degenerations

Do you have any history of eye disease, injuries, or surgeries not listed above? If so, please list:

____

DRY EYE SCREENING

Rate the **severity** of each symptom:

0= None 1= Tolerable 2= Uncomfortable 3= Bothersome 4= Intolerable

	0	1	2	3	4
Dryness/Grittiness					
Soreness/Irritation					
Burning					
Watering					
Eye Fatigue					

Rate the **frequency** of each symptom:

0= Never 1= Sometimes 2= Often 3= Constantly

	0	1	2	3
Dryness/Grittiness				
Soreness/Irritation				
Burning				
Watering				
Eye Fatigue				

Have you been using any eye drops? ☐ Yes → Name of Drop ________ Frequency of Use ________

☐ No

Used within last 4 hours? ☐ Yes ☐ No

YOUR VISION

	Y	N
Are you happy with your vision?	☐	☐
Are you interested in **contacts**?	☐	☐
Are you interested in **laser vision correction?**	☐	☐
Are you interested in **eliminating** the need for glasses or contact lenses **non-surgically?**	☐	☐
Have you worn **contacts** before?	☐	☐
Do you currently wear glasses?	☐	☐

Please mark if you are experiencing any of the following **vision issues:**

- ☐ Blurred Vision
- ☐ Eyestrain
- ☐ Eye Pain
- ☐ Light Sensitivity
- ☐ Headache
- ☐ Poor Night Vision
- ☐ Night Glare
- ☐ Double Vision
- ☐ Total Loss of Vision
- ☐ Floaters
- ☐ Flashes of Light
- ☐ Loss of Side Vision

Do you currently wear contacts? ☐ Yes ☐ No

GLASSES

How old are your glasses? ________

When do you wear your **glasses**?

- ☐ Full time
- ☐ For near only
- ☐ For distance only
- ☐ For computer use
- ☐ When not wearing contacts
- ☐ Other ________

Are you planning to get new glasses this year?

- ☐ Yes
- ☐ No
- ☐ Only if needed
- ☐ New lenses in current frame

CONTACT LENSES

Do you wear your contact lenses daily? ☐ Yes ☐ No

How often do you replace your lenses? ________

What type of lenses do you wear? ________

How many hours per day do you wear them? ________

What type of solution or drops do you use? ________

How often do you sleep in your lenses? ________

How old are your current lenses? ________

YOUR HEALTH

OVERALL HEALTH:

- [ ] No Health Problems
- [ ] Developmental Delays
- [ ] Cancer
- [ ] Fatigue Syndrome
- [ ] Other ______________

EAR, NOSE AND THROAT:

- [ ] None
- [ ] Hearing Loss
- [ ] Sinusitis
- [ ] Dry Mouth
- [ ] Laryngitis
- [ ] Other ______________

PSYCHIATRIC:

- [ ] None
- [ ] Depression
- [ ] Attention Deficit
- [ ] Anxiety Disorder
- [ ] Bipolar Disorder
- [ ] Other ______________

CARDIOVASCULAR:

- [ ] None
- [ ] Hypertension
- [ ] Stroke/CVA
- [ ] Heart Disease
- [ ] Vascular Disease
- [ ] Congestive Heart Failure
- [ ] Other ______________

HEMATOLOGIC/LYMPHATIC:

- [ ] None
- [ ] Anemia
- [ ] Large Volume Blood Loss
- [ ] Ulcer
- [ ] Hypercholesteremia
- [ ] Other ______________

RESPIRATORY:

- [ ] None
- [ ] Cigarette Smoker
- [ ] Asthma
- [ ] Bronchitis
- [ ] Emphysema
- [ ] Chronic Obstruction
- [ ] Sleep Apnea
- [ ] Other ______________

GASTROINTESTINAL:

- [ ] None
- [ ] Crohn's
- [ ] Colitis
- [ ] Ulcer
- [ ] Acid Reflex
- [ ] Celiac Disease
- [ ] Other ______________

GENITOURINARY:

- [ ] None
- [ ] Kidney Disease
- [ ] Prostate Disease/Cancer
- [ ] STD-Herpetic/Chlamydia
- [ ] Benign Prostate Hypertrophy
- [ ] Pregnant ________ weeks
- [ ] Nursing
- [ ] Other ______________

MUSCULOSKELETAL:

- [ ] None
- [ ] Arthritis
- [ ] Osteoarthritis
- [ ] Fibromyalgia
- [ ] Muscular Dystrophy
- [ ] Ankylosing Spondylitis
- [ ] Osteoporosis
- [ ] Gout
- [ ] Other ______________

INTEGUMENTARY (*body's outer layer*):

- [ ] None
- [ ] Eczema
- [ ] Rosacea
- [ ] Psoriasis
- [ ] HSV/Cold Sores
- [ ] Herpes Zoster/Shingles
- [ ] Other ______________

ALLERGIC/IMMUNE:

- [ ] None
- [ ] Drug Allergies
- [ ] Environmental Allergies
- [ ] Rheumatoid Arthritis
- [ ] Lupus
- [ ] Sjögren's Syndrome
- [ ] Other ______________

NEUROLOGICAL:

- [ ] None
- [ ] MS
- [ ] Epilepsy
- [ ] Cerebral Palsy
- [ ] Tumor
- [ ] Stroke/CVA
- [ ] Migraine
- [ ] Other ______________

ENDOCRINE:

- [ ] None
- [ ] Type 1 Diabetes
- [ ] Type 2 Diabetes

If diabetic, please list:
Last A1C: __________
Average BSL: __________

- [ ] Thyroid Dysfunction
- [ ] Hormonal Dysfunction
- [ ] Other ______________

MEDICATIONS AND PHARMACY

For those on multiple medications, you are welcome to provide a list instead if you prefer.

Please list current medications: ______________________

And their purpose: ______________________

If you are taking any **eye vitamins**, please list: ______________________

Preferred Pharmacy ______________________

Pharmacy Location ______________________

Medication Allergies ______________________

Other Allergies ______________________

FAMILY HISTORY

☐ *Mark if family history is unknown. You may skip to the next section.*

Please mark any that apply:

	Mother	Father	Sibling	Child	Grandparent	Unsure
Cancer						
Diabetes						
Hypertension						
Cataract						
Glaucoma						
Corneal Disease						
Macular Degeneration						
Retinal Detachment						