LAKESIDE EYECARE, Optometry

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Member
American Optometric Association

Thank you for choosing our practice for your eyecare needs. Our objective is to provide you the best in vision care. Please fill in all of the spaces. If you have any questions or concerns regarding this form, our staff will be happy to help you.

PATIENT INFORMATION

Patient Name_____ Date of birth: _____Age_____

Address: _____City:_____ ST: _____ Zip _____

Occupation: _____ Employer: _____ Work #: _____

Home #; _____Cell #: _____ Email:_____

Vision Ins: _____

Major Medical Insurance: _____

How did you hear of our office? _____

HEALTH HISTORY

Today's examination is for: Routine Examination_____ Eyeglasses_____ Contact Lenses_____ Laser Vision Care_____

Other _____

Date of last eye examination _____ with Dr._____

Are you taking medication? ___Yes ___No If yes, please list: _____

_____

_____

Do you have any allergies to medication? ___ Yes ___No If yes, what are you allergic to? _____

Do you or anyone in your immediate family have a history of the following? S--Self F--Family

Diabetes___ Thyroid Condition___ High-blood Pressure___ Cataract___ Glaucoma___ Macular Degeneration.___

CURRENT VISION PROBLEMS

Blur at distance with glasses _____

Blur at near with glasses _____

Blur at distance without glasses_____

Blur at near without glasses_____

Frequent headaches _____

Do your eyes feel dry or gritty? _____

Sensitivity to light_____

Difficulty seeing at night _____

How many hours per day do you use a computer?_____ Tablet_____ Smart Phone_____

Have you ever worn contact lenses? Yes _____ No _____ If yes, what type?

Last time worn?_____Problems? _____

Are you interested in contact lenses? ____Yes ____No What type? _____

Are you interested in laser eye surgery? ____Yes ____No

Signature _____ Date_____