Date: ____________

Welcome to Eye Design!

Please take a moment to complete this form. Thank you.

Name: Last________________________ First____________________ Middle Initial___ Mr. Mrs. Ms. Miss Dr.

Patient's Social Security Number: ____________________________

Family physician name________________________

Are you taking ***ANY*** medication or vitamin supplements ? Yes ☐ No ☐

If yes, what is it, what's being treated, and how often do you take it?

____

Are you allergic to ***ANY*** medication(s)? Yes ☐, No ☐ If yes, which medication(s)____________________________

Without any vision correction being used, do you suffer from any of the following:

	YES	NO		YES	NO
near vision blur	☐	☐	dry eyes	☐	☐
distance vision blur	☐	☐	watery eyes	☐	☐
middle distance vision blur (dashboard/computer)	☐	☐	pain in/around eyes	☐	☐
			red eyes	☐	☐
double vision	☐	☐	changing focus from near to distance	☐	☐
headaches	☐	☐	changing focus from distance to near	☐	☐
seeing spots/lines	☐	☐	outdoor glare	☐	☐
seeing flashes	☐	☐	indoor glare	☐	☐
seeing haloes	☐	☐	eye strain	☐	☐

Date of last eye examination____________Were your pupils dilated (drops) at your last examination? Yes ☐, No ☐

Date of last physical _________ Do you use a computer? Yes ☐, No ☐ If yes, ___hrs/day ___days/wk

Special vision requirements (occupation/computer/hobbies/sports)______________________________

Do you or any ***blood*** relatives currently suffer from or have a history of:

	SELF		FAMILY			SELF		FAMILY	
	YES	NO	YES	NO		YES	NO	YES	NO
Glaucoma	☐	☐	☐	☐	High blood pressure	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	Diabetes	☐	☐	☐	☐
Amblyopia (lazy eye)	☐	☐	☐	☐	Multiple sclerosis	☐	☐	☐	☐
					Cardiac disease	☐	☐	☐	☐
Color blindness	☐	☐	☐	☐	***Any*** Cancer	☐	☐	☐	☐
Retinal macular degeneration	☐	☐	☐	☐	Keratoconus	☐	☐	☐	☐
					Strabismus (crossed eye)	☐	☐	☐	☐
Retinal detachments	☐	☐	☐	☐					

Many diseases of the body have eye health consequences. For example, diabetes is one of the leading causes of blindness. Therefore, it is imperative we acquire an in depth medical history. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them. This information is also critical in the event we need to prescribe certain medications.

	YES	NO		YES	NO		YES	NO
Syphilis	☐	☐	Chronic renal failure	☐	☐	Smoker/Tobacco use	☐	☐
Sinus problems	☐	☐	Shingles/herpes	☐	☐	Alcohol/Substance abuse	☐	☐
Allergies	☐	☐	Lyme disease	☐	☐	Seizures	☐	☐
Arthritis	☐	☐	High cholesterol	☐	☐	Asthma	☐	☐
Sarcoidosis	☐	☐	HIV	☐	☐	Emphysema	☐	☐
Lupus	☐	☐	Mitral valve prolapse	☐	☐	Chronic bronchitis	☐	☐
Psoriasis	☐	☐	Arteriosclerosis	☐	☐	Liver disease	☐	☐
Crohn's disease	☐	☐	Graves/thyroid disease	☐	☐	Myasthenia gravis	☐	☐
Ankylosing Spondylitis	☐	☐	Chronic obstructive pulmonary disease	☐	☐	Stevens Johnson Syndrome	☐	☐
Reiters syndrome	☐	☐						

(OVER)

Do you suffer from ***Any*** diseases not listed on the previous page? Yes ☐, No ☐
If yes, what disease(s)________________________________

If you currently wear eyeglasses, does your spare pair have your correct prescription? Yes ☐, No ☐

If you currently wear prescription sunglasses, do they have UV (ultra-violet) protection? Yes ☐, No ☐, Not sure, ☐

If you currently wear eyeglasses, are there certain times when you would rather not? (for example-sports, business presentations, social occasions etc.) Yes ☐, No ☐

Would you like to be evaluated for Laser Vision Correction? Yes ☐, No ☐

Have you ***ever*** worn contact lenses? Yes ☐, No ☐

If yes, check all that apply even if worn for only a short time:
soft ☐, hard ☐, gas permeable ☐, daily wear ☐, extended wear ☐, disposable ☐, monovision ☐, tinted ☐, bifocal ☐, planned replacement ☐

Do you currently wear contact lenses? Yes ☐, No ☐

If yes; soft ☐, hard ☐, gas permeable ☐, daily wear ☐, extended wear ☐, disposable ☐, monovision ☐, tinted ☐, bifocal ☐, planned replacement ☐

If you currently wear contact lenses, do your backup eyeglasses have your correct prescription? Yes ☐, No ☐

Would you like to be fit with contact lenses today? Yes ☐, No ☐

If yes, would you like to be fit with any of the following? Check all that apply. {Note: all lenses are not suitable for all patients. We will discuss what's available for your particular prescription, fitting parameters and lifestyle after the completion of your examination} soft ☐, gas permeable ☐, daily wear ☐, extended wear ☐, weekly disposable ☐, daily disposable ☐, bifocal ☐, monovision ☐, planned replacement ☐ tinted ☐

Answer questions 1-10 ***only if you currently wear contact lenses. If you do not currently wear contact lenses, skip to question 11.***

1. How old are your lenses?______________
2. If you are NOT currently wearing disposable lenses, how often do you usually replace your lenses__________
3. How many years have you worn lenses?______________
4. What disinfection system do you use? Heat ☐, Cold ☐
5. What brand of solution do your lenses soak in overnight? B&L Renu ☐, Alcon Optifree ☐, Ciba AO Sept ☐, Not sure of brand ☐, Other______________________________
6. What is your typical wearing schedule? _____hrs/day, ____days/week
7. If you wear disposable lenses, what is your usual wearing schedule? dispose of daily ☐, dispose of weekly ☐
8. Are you having ***any*** problems with your lenses? Yes ☐ No ☐
9. Would you like to enhance or change your eye color with lenses? Yes ☐ No ☐
10. Would you like to be fit/refit with any of the following? Check all that apply. soft ☐, gas permeable ☐, daily wear ☐, extended wear ☐, weekly disposable ☐, daily disposable ☐, monovision ☐, tinted ☐, bifocal ☐, planned replacement ☐

{Note: all lenses are not suitable for all patients. We will discuss what's available for your particular prescription, fitting parameters and lifestyle after the completion of your examination}

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11. I was referred by:
My family doctor or ophthalmologist ______________ Friend/family (name)

Payment is expected in full when professional services are rendered. ***We do not bill. All orders placed, require a 50% deposit. Balance must be paid at the time of dispensing.***
Desired method of payment: cash ☐, check ☐, mastercard ☐, discover ☐, AE ☐, visa ☐
Who is responsible for your bill (those charges not covered by insurance)?
self ☐, other ________________________

Thank you for completing this form. Please return it to the front desk and we will be with you shortly.