Simply the Best
Daynes EyeCare

O M Please Print
O F Patient Name _____ Mr O Ms O
Last I First Mrs O Miss O
Rev O Dr O

Date of Birth _____

Mailing Address _____

City _____ St _____ Zip _____

Home Phone _____ Daytime Phone _____

Cell Phone _____ Text? YES O NO O

E-Mail Address _____

Occupation _____

Insurance _____

Referred By _____

Family Physician _____

Age of present glasses? ___ Last Eye Exam Date _____ From Dr. _____

	Yes	No
Do you take any medications? Please list: _____	O	O
What conditions do the medications treat? _____		
Are you allergic to any medicine? Please list: _____	O	O
Are you currently under the care of a physician for any of the following conditions?	O	O

O Diabetes O High Blood Pressure O Thyroid O Arthritis O Pregnancy
O High Cholesterol O Asthma O Other _____

Is there a family history of any of the following conditions?.....
O Diabetes O High Blood Pressure O Thyroid O Cataract O Glaucoma
O Blindness O Lazy Eye

Have you ever had a reaction to eye drops?.....	O	O
Do you have Glaucoma or family history of Glaucoma?.....	O	O
Do you have Cataracts? Or have you had Cataracts removed?.....	O	O
Do you have frequent headaches?.....	O	O
Does sunlight or bright light bother you?.....	O	O
Do you ever see double? When?.....	O	O
Are you color blind?.....	O	O

Special tasks/hobbies? Please list: _____

Following questions for contact lens wearers only:

Do you have any previous contact lens experience?.....	O	O
Do you currently wear contact lenses?.....	O	O

How old are your contact lenses? _____
Types of lenses worn? Soft: O Sphere O Astigmatism O Bi-focal O Extended wear
Hard: O Gas Permeable O Gas Permeable Toric

New

Patient: (last) (first) Age: Date:

Appt: Walk-In In Out Tech

Reason for Visit: ☐ Eye Exam ☐ Eye Exam & CL Fitting ☐ CL Fitting

PRETEST

OLD RX	SPHERE	CYLINDER	AXIS	PRISM	ADD	SV Bif Tri No Line
Last Exam Date	R					
	L					

Age of Glasses	VA (S)	FAR	NEAR	VA (C)	FAR	NEAR
		R 20/	20/	SPEC ☐	R 20/	20/
		L 20/	20/	CL ☐	L 20/	20/

Color Vision: **Pass** ☐ **Fail** ☐ Visual Field: Norm ☐ Abnorm ☐

Depth Secs	B.P.	NCT R	NCT L	IOP	APPL

LEE:

☐ Glasses ☐ Broken ☐ Lost ☐ Scratched

DR. EXAMINATION

Brief History / Chief Complaint

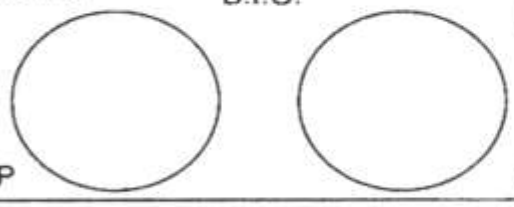
P: V: NPC:

Blur F N HA Water Itch Burn Pain Tire Diz Floater Diplopia VA Loss

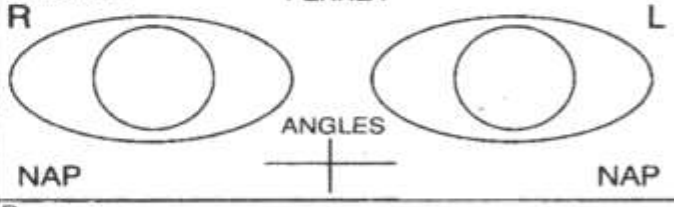
Subj		Add	Near Tests / Retinoscopy
R	20/	20/	R
L	20/	20/	L

Phoria: Far: Horiz Vert. Near: Horiz Vert.

Internal R B.I.O. L NAP NAP



External R PERRLA L ANGLES NAP NAP



R: L: A / V C / D Mac Ret

DPA Phenylephrine: 2½ % ☐ Proparacaine % ☐ Tropic .5% ☐ 1% Cyclopent 0.5% ☐ 1% ☐

Remarks / C.L. Fitting ± 2.00

Amsler Grid: P F S

Optos:

Dx:

Prg:

Rec:

CLS RX Finalized ☐

New Rx	R	Add	Dr. Initials
P.D. /	L		

Return: 6 months. ☐ 1 yr. ☐ 1½ yr. ☐ 2 yr. ☐ Other ☐ _____