First Name	MI	Last Name	Sex	Birthdate	Age

Please update the following information, or check box if unchanged from last visit: []

Home Address	City	State	Zip	Home Phone	Daytime Contact Phone

Occupation	Employer	Referred By

RETURNING PATIENT HISTORY

List any changes to your eyes or vision since last visit:______________________________

List any changes in health since last visit:______________________________

List any changes in family medical history since last visit:______________________________

List any medications you take: ______________________________

____

Are you allergic to any medication? [] No [] Yes If yes, list:______________________________

Contact lens wearers only:

Which type of contact lenses do you 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:__________

Do you currently have problems with any of the following:

	Yes	No	Office use only	
Migraines	[]	[]	346.00	V
Floaters in vision	[]	[]	379.24	E
Flashes in vision	[]	[]	368.15	V
Visual disturbance	[]	[]	368.10	V
Visual blind spots	[]	[]	368.4_	V
Visual discomfort	[]	[]	368.13	V
Sudden visual loss	[]	[]	368.11	EVA
Eyestrain	[]	[]	368.13	V
Light sensitivity	[]	[]	368.13	V
Visual halos	[]	[]	368.15	V
Amblyopia - “lazy eye”	[]	[]	368.0_	V

	Yes	No	Office use only
Glaucoma	[]	[]	VPG
Macular Degeneration	[]	[]	EVP
Retinal Disease	[]	[]	EVP
Lupus	[]	[]	V
Diabetes	[]	[]	
High Blood Pressure	[]	[]	