

# WELCOME TO ADVANCED EYECARE!

Please take a moment to fill out the questions below. This will assist us in determining your special vision needs.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Marital Status:  Single  Married  Divorced  Widowed Sex:  Male  Female  
Home Telephone \_\_\_\_\_ Daytime or Work Telephone \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Student/Grade \_\_\_\_\_  
Social Security Number \_\_\_\_\_ E-mail \_\_\_\_\_  
Family members living at home \_\_\_\_\_

**NAME OF RESPONSIBLE PARTY and address (if different from patients)** \_\_\_\_\_

**DO YOU HAVE ANY VISION CARE OR EYEWEAR INSURANCE WHICH MAY COVER TODAY'S CHARGES? YES \_\_\_\_\_ NO \_\_\_\_\_**

If you have insurance coverage - please fill out this area.

Primary Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_  Vision  Medical  
Relationship to Insured:  Self  Spouse  Child  Other  Vision  Medical  
Secondary Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_  Vision  Medical  
Relationship to Insured:  Self  Spouse  Child  Other

Approximate date of last eye examination \_\_\_\_\_ By Doctor \_\_\_\_\_

Do you have glasses now? \_\_\_\_\_ Do you wear them? \_\_\_\_\_ When? \_\_\_\_\_

Are your eyes or vision giving you any problems? \_\_\_\_\_

Do you notice these problems occurring at distance? \_\_\_\_\_ At near? \_\_\_\_\_

Are you interested in contact lenses? \_\_\_\_\_ Have you ever worn contacts? \_\_\_\_\_ When? \_\_\_\_\_

Have you ever received vision therapy or eye exercise? \_\_\_\_\_

## General Health (past or present)

\_\_\_\_\_ allergies \_\_\_\_\_ skin conditions \_\_\_\_\_ eye surgery \_\_\_\_\_ headaches  
\_\_\_\_\_ drug reactions \_\_\_\_\_ heart disease \_\_\_\_\_ eye or head injuries \_\_\_\_\_ diabetes  
\_\_\_\_\_ seizures \_\_\_\_\_ eye disease \_\_\_\_\_ high blood pressure \_\_\_\_\_ glaucoma

Explain \_\_\_\_\_

## Family History

\_\_\_\_\_ diabetes \_\_\_\_\_ glaucoma \_\_\_\_\_ blindness \_\_\_\_\_ stroke  
\_\_\_\_\_ heart disease \_\_\_\_\_ high blood pressure \_\_\_\_\_ cataracts \_\_\_\_\_ eye disease

Who is your family Physician? \_\_\_\_\_ City \_\_\_\_\_

Are you being treated for any medical conditions? \_\_\_\_\_ If so, what? \_\_\_\_\_

List any medications you are currently taking (including hormones or birth control) \_\_\_\_\_

List any medicines you are allergic to \_\_\_\_\_

Do any of the following options appeal to you:

Thinner lenses  Lightweight lenses  Lenses that change in the sun  No-line bifocals or trifocals

Do headlights bother you at night? \_\_\_\_\_ Do you spend a fair amount of time in the sun? \_\_\_\_\_

Do you participate in any of the following activities?

<input type="checkbox"/> Water skiing	<input type="checkbox"/> Golfing	<input type="checkbox"/> Computer	Hobbies: _____
<input type="checkbox"/> Bicycling	<input type="checkbox"/> Snow skiing	<input type="checkbox"/> Piano/organ	_____
<input type="checkbox"/> Scuba diving	<input type="checkbox"/> Running	<input type="checkbox"/> Woodwork	_____
<input type="checkbox"/> Softball	<input type="checkbox"/> Fishing	<input type="checkbox"/> Shooting	_____
<input type="checkbox"/> Tennis	<input type="checkbox"/> Swimming	<input type="checkbox"/> Racquetball	_____

**How were you referred to our office?**  yellow pages  Radio  Insurance  
family member \_\_\_\_\_ friend \_\_\_\_\_ other \_\_\_\_\_