WELCOME TO DOUGLAS FAMILY EYECARE

Patient Name_____

What is the major purpose of this visit? List

_____

Do you have any problems with your present contact lenses or or glasses?

_____W

Who may we thank for referring you to our office? Name of friend or relative. _____

If not referred, how did you choose our office for your needs?

☐ Another Doctor
☐ Saw sign/building
☐ Yellow Pages
☐ Insurance list
☐ Newspaper
☐ Other

FAMILY MEDICAL / EYE HISTORY (Check all that apply.)

Is there a family medical history of any of the following?

	Relationship
Blindness	_____
Cataracts	_____
Corneal Problems	_____
Glaucoma	_____
Lazy Eye	_____
Macular Degeneration	_____
Retinal Problems	_____
Diabetes	_____
Heart Disease	_____

The information on this confidential case history form is critical to the evaluation of your vision and health.

PATIENT MEDICAL HISTORY

Name of Family Physician_____
Town _____
Date of Last Physical Check up _____

CURRENT MEDICATIONS (Rx or over-the-counter)
name of medications including eye drops, vitamins & birth control pills.

_____

_____

Allergies to Medications: ☐ YES ☐ NO
If yes, what _____

Have you ever been diagnosed or treated for the following?

☐ Allergies ☐ Diabetes ☐ Thyroid
☐ Asthma ☐ Arthritis ☐ Cancer
☐ Nerves ☐ Cholesterol ☐ Heart Disease
☐ High Blood Pressure ☐ Kidney Disease
☐ Other _____

PATIENT EYE HISTORY

Date of Last Eye Exam? _____
By Whom? _____
Have you ever tried contact lenses? ☐ Yes ☐ No
Do you currently wear contact lenses? ☐ Yes ☐ No
What kind? _____
Solutions Used? _____
How often do you replace your lenses? _____
Are you satisfied with the vision and comfort? _____
Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? _____

Do you ….. (Check box if your answer is "yes")
☐ Work at a computer? How long? ___ hrs/days
☐ Think you might benefit from thinner, lighter lenses?
☐ Have interest in a "test-drive" of the latest contact lens design?
☐ Spend time outdoors? (How much?) ____ hrs/week
☐ Have prescription sunglasses?
☐ Prefer not to wear your glasses at times?
☐ Want information on Laser Vision Correction Surgery
☐ Have interest in a non-surgical approach to vision correction?

WELCOME TO DOUGLAS FAMILY EYECARE

Have you ever been diagnosed or treated for the following?

☐ Cataracts ☐ Corneal Abrasion ☐ Eye Infection ☐ Eye Injury
☐ Glaucoma ☐ Iritis/Uveitis ☐ Lazy Eye ☐ Macular Degeneration
☐ Retinal Detachment ☐ Other Eye Disorders

Do you experience or have you ever experienced?

☐ Blurry Vision ☐ Burning ☐ Floater/Spots ☐ Grittiness
☐ Tearing ☐ Itchiness ☐ Headaches ☐ Double vision
☐ Flash of light ☐ Sunlight Sensitivity ☐ Occasional Dryness
☐ Trouble seeing at night ☐ Uncomfortable glasses
☐ Crossed eye/eye turn

Your eyewear is an investment in your personal appearance. It is self-expression. It is an accessory to help you see better and live better.

YOUR LIFESTYLE

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs.

How long have you been wearing glasses? _____ Contacts: _____
What percent of time do you wear your glasses? _____ Contacts: _____
Do you wear prescription sunglasses? ☐ Yes ☐ No Do you wear non-prescription sunglasses? ☐ Yes ☐ No

When do you wear your corrective eyewear?	Glasses	Sunglasses	Contacts
All of the time	☐	☐	☐
For reading/working	☐	☐	☐
For driving	☐	☐	☐
For sports/recreation	☐	☐	☐
Other _____	☐	☐	☐

What is your occupation? _____

Which of the following do you do regularly? (Check all that apply)

☐ Night driving ☐ Work outdoors ☐ Commute 20+ min by car
☐ Work with small objects ☐ Work under fluorescent light ☐ Read for long periods
☐ Work on a computer ☐ Travel on airplanes ☐ Watch TV for 3+ hrs daily
☐ Work at a desk ☐ Frequently alternate between indoors & outdoors
☐ Other _____

What features will be important in choosing your new glasses? (check all that apply)

☐ Fit ☐ Durability ☐ Weight ☐ Brand ☐ Fashion trends ☐ Lens Type
☐ Frame color ☐ Lens color ☐ Image ☐ Other ☐ Lens Thickness