WELCOME TO DOUGLAS FAMILY EYECARE

Patient Name_____

What is the major purpose of this visit?

_____

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

_____

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)
List 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