

Patient Information:

Name _____ Birthdate: _____
Home Phone: _____ Cell Phone: _____
Address _____ City _____ Zip _____
SS # _____
Email: _____

To better serve your visual needs, please take a moment to fill out our questionnaire.

Employer _____ Occupation _____
Employer Address _____ Employer Phone () _____ - _____
Emergency Contact (name and phone#): _____

Reason for visit: _____

Medical History: Name of your primary Dr. _____

Review of Systems: Do you have any problems with any of the following? (check all that apply)

cancer stomach/GI ear/nose/throat genital/urinary nervous system musculoskeletal
 mental skin cardio blood/lymph respiratory allergies

Explanation of any of the above:

List all surgeries you've had: _____

List any prescription or non-prescription medications you take: _____

Are you allergic to any medications? _____

Please note any history of the following eye diseases for only **you, your parents, grandparents, or siblings:**

<u>Disease</u>	You	Family	Relationship to you/explanation
blindness/vision loss	_____	_____	_____
cataract	_____	_____	_____
glaucoma	_____	_____	_____
macular degeneration	_____	_____	_____
retinal disease	_____	_____	_____
cancer	_____	_____	_____
diabetes	_____	_____	_____
heart disease	_____	_____	_____
hypertension	_____	_____	_____

Social History:

Do you drive? yes / no Please list any vision difficulties while driving: _____

Do you use tobacco products? yes / no Drink alcohol? yes / no Use any other substances? yes / no

How did you first hear about our office? _____

Welcome to Performance Eyecare!

Please take a moment to answer a few questions so that your Doctor can make the best recommendations for you.

1. Do you use a computer? yes no If so, how many hours a day? 1-4 5-8 8-12

Please **circle** any visual symptoms related to using the computer:

Eyestrain / Burning / Watering / Blurred Vision / Headaches / Light Sensitivity / none

How long does it take before your eyes feel the above symptoms? _____

2. In your spare time, what are your favorite things to do? (please list)

3. Can you think of any situations where you feel that your vision could be better? (please list)

4. If you currently wear eyeglasses, does your spare pair have your correct prescription? Yes No

5. Do you currently wear sunglasses with UV protection? Yes No

6. If you currently wear eyeglasses, are there certain times when you would rather not? (for example-sports, business presentations, social occasions etc.)? Yes No

7. If you currently wear contact lenses, do your eyeglasses have your correct prescription? Yes No

8. Are you interested in finding out more about lasik surgery? Yes No

As a courtesy to other patients, and to help us remain on schedule, we ask that you please turn off your cell phone at this time until the Doctor has completed your examination.

Services We Offer

- Lasik
- Non-surgical Vision Correction / Vision Retainers
- Contact Lenses
- Diabetic Eye Care
- Treatment of Eye Diseases (glaucoma, macular degeneration, etc.)
- Surgical treatment for Dry Eyes
- On-site eyeglass laboratory