HISTORY FORM UPDATE

Please fill this form in and bring this form with you when you come in for your appointment

Today's Date: _____

Name: _____ Age: _____

What is your reason for seeking care at this time:

_____

_____

Approximately how long ago was your last eye exam? _____

By what doctor or office? _____

Do you now wear glasses or contact lenses?

Please Circle: Glasses Contact Lenses No Correction

Please Circle: RGP Soft

Average wearing time per day (hrs.): _____

Do you wear them over night? Yes No

Name of solutions used to care for them? _____

Have you ever had any eye disease, eye injury, or eye surgery? Yes No

Please Circle: Disease Injury Eye Surgery No

If yes, please explain:

_____

_____

Circle any of the following eye symptoms or problems that you are have experienced:

light	Floaters	vision	turned eye		itching
burning	dryness	redness	lazy eye		cataracts
glaucoma	eye strain	light sensitivity		blurred vision w/correction	

Check any of the following medical conditions that you have?

Allergies	High blood pressure
Diabetes	Frequent Headaches
Other:	

Personal Physician(s): _____

Please list any medications you are currently taking:

_____

_____

List any allergies to medications: _____

_____

Does anyone in your **family** have any eye disease or health problems (i.e. glaucoma, macular degeneration, eye turns, diabetes, high blood pressure, etc.)? Yes No

If yes, please list who & what: _____

_____

I would like more information about:

contact lenses	eye disease prevention	turned eye
refractive laser surgery	glaucoma	cataracts

Other: _____

Exams are to be paid for at the time of service. Materials are requested to be paid in full when ordered, and require a minimum of 50% deposit at the time of order, the balance to be paid when dispensed. No materials are dispensed until paid in full.

Village Optical