

PREMIUM EYECARE  
**Patient Profile (Please print)**

Date \_\_\_\_\_

Name:		Home Phone:	Work Phone:	Cell Phone:
Address:		City:	State:	Zip code:
Date of Birth:	Social Security #:	Occupation:	Email address:	
Date of Last eye exam:	Location of last exam:	Date of last physical exam:	Name of Physician:	
Name of Employer:	List the Insurance Carrier that Provides Your Vision Benefits:		I.D. / Social Security # of Primary Insured:	
What type of exam are you here for? <input type="checkbox"/> Spectacle <input type="checkbox"/> Contact lens <input type="checkbox"/> Both		Reason for today's exam:		Do you wear glasses presently? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contact lenses presently? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever worn contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you interested in trying contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	

How did you find us/ Referred By? \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

Are you active in sport? \_\_\_\_\_

Are you having problems with your present eyeglasses or contact lenses? \_\_\_\_\_

Do you use computers? (if yes, how many hours?) \_\_\_\_\_

Do you take any medication? (If yes, list) \_\_\_\_\_

Are you allergic to medication? (If yes, list) \_\_\_\_\_

Have you ever had eye injury or surgery? (If yes, describe) \_\_\_\_\_

**Family Health History**

(Check those your family member has/had)

- Allergies
- Asthma/lung condition
- Cancer
- Diabetes
- Drug sensitivity
- Hay fever
- Heart condition
- High blood pressure
- Kidney problems
- Migraine headaches
- Skin conditions
- Thyroid condition
- Tuberculosis
  
- Blindness
- Cataracts
- Glaucoma
- Lazy eye
- Poor color vision
- Retinal disease
- Turned eye
- Other eye diseases (List)  
\_\_\_\_\_

**Patient's Health History**

(Check those you have/had)

- Allergies
- Asthma/lung condition
- Blackouts
- Cancer
- Diabetes
- Drug sensitivity
- Hay fever
- Heart condition
- Hepatitis
- High blood pressure
- Kidney problems
- HIV / AIDS
- Migraine headaches
- Skin conditions
- Thyroid condition
- Tuberculosis
  
- Blindness
- Cataracts
- Glaucoma
- Poor color vision
- Retinal disease
- Turned eye

**Patient's Visual Symptoms / signs**

(Check those you have/had)

- Distance vision blurred
- Near vision blurred
- Discomfort at distant visual tasks
- Discomfort at near visual tasks
- Light sensitivity
- Double vision
- Occasional vision changes
- Temporary loss of vision
- See flashing lights
- See floaters or spots
- See haloes / colors around light
- Eyestrain
- Headaches
- Burning eyes
- Red eyes
- Itching eyes
- Watery eyes
- Dry eyes
- Twitching eyelid
- Swollen eyes