V·EYE·P
eyecare + eyewear

ACCOUNT NUMBER ______________________

O New O Est.

Patient Information

LAST NAME ______________________ FIRST NAME ______________________ DATE OF BIRTH ______________

How did you hear about our office?

- O Online Search
- O Insurance
- O Co-worker
- O Driving by/Signage
- O Friends/Family
- O Other

Eye Health + Medical History

Please check any ocular symptoms you are experiencing:

- O Blurry Vision Distance or Near
- O Tired Eyes/Digital Eye Strain
- O Night Vision Problems
- O Headaches
- O Double Vision
- O Sudden Loss of Vision
- O Glare/Light Sensitivity
- O Flashes and/or Floaters
- O Red Eyes
- O Dry Eyes
- O Itchy/Watery Eyes
- O Eye Irritation/Pain
- O Contact Lens Discomfort

Please check any medical conditions you are currently being treated for:

- O Glaucoma
- O Macular Condition
- O Hypertension/High Blood Pressure
- O Diabetes
- O Elevated Cholesterol
- O Allergies
- O Sinus Congestion
- O Asthma
- O Dry Throat/Mouth
- O Thyroid Disease
- O Arthritits
- O Cancer
- O Gastrointestinal Disorders
- O Psychiatric Disorders
- O Pregnancy
- O Other ______________

Please check if you have a family history of any of the following conditions:

- O Glaucoma
- O Macular Degeneration
- O Other Eye Diseases
- O Diabetes
- O Hypertension
- O Cancer

Please list your current medications:

Please list any allergies to medications:

Lifestyle

Do you wear glasses? Yes No

- If yes, how old is your current pair? __________

Do you wear contacts? Yes No

- If yes, rate your comfort (1=Poor to 5=Excellent)
  1 2 3 4 5
- If no, do you have any interest in contact lenses? Yes No

Do you wear sunglasses when driving or outdoors? Yes No

Do you wish you had better eyewear solutions for any activities you participate in? Yes No

Approximately how many **combined** hours per day do you spend using computers, tablets, and phones?

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