EUREKA
EYE CARE

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Welcome Back

We are pleased to welcome you back to our practice.

The following information will aid your doctor in providing the most complete care possible.
Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to assist you.

PATIENT INFORMATION

Name _____ Age _____ Birth date _____ Date _____

Occupation / Employer _____ Grade / School _____

Address Change? _____

Phone (Home) _____ Phone (Work) _____ Phone (Cell) _____

REASON FOR YOUR VISIT

Please place a "√" in any ❒ that applies to today's visit.

- ❒ Annual Check-up / Not Having Any Problems
- ❒ Want Stronger Prescription for Distance Tasks
- ❒ Want Stronger Prescription for Near Tasks
- ❒ Want Bifocals or Reading Spectacles
- ❒ Replace Lost or Broken Spectacles
- ❒ Need Second Pair Spectacles or Sunglasses
- ❒ Need More Contact Lenses
- ❒ Would Like to Try Contact Lenses
- ❒ Need Reading Glasses Over Contact Lenses
- ❒ Trouble Using Eyes Comfortably
- ❒ Other _____

Do you wear glasses? ❒ No ❒ Yes

❒ All the time ❒ Occasionally

❒ For distance tasks ❒ For near tasks ❒ Computer

Do you wear contact lenses? ❒ No ❒ Yes Type _____

Replacement Schedule _____ Hours Worn /Day _

Pairs Left ____ Solutions used _____

To get a better sense of how you use your eyes, are there any hobb participate in on a regular basis?

_____

EYE / VISION CONCERNS

Please place a "√" in any ❒ to indicate if you are experiencing any of the following.

- ❒ Blurred Vision – Distance
- ❒ Blurred Vision – Near
- ❒ Burning Eyes

HEALTH HISTORY

Date of your last physical _____

Members	Yourself	Family
Anemia	❒	❒
Arthritis	❒	❒
Asthma	❒	❒
Brain Tumor	❒	❒

Please place a "√" in any ❒ to indicate if you or any blood relative has had any of the following problems (including parents, grandparents, uncle, aunts, or siblings).

Members	Yourself	Family
HIV / AIDS	❒	❒
Kidney Disease	❒	❒
Lupus	❒	❒

- ❒ Crossed Eyes
- ❒ Crusty Eyelids
- ❒ Double Vision
- ❒ Dry Eyes
- ❒ Eye Infection / Injury
- ❒ Eye Pain
- ❒ Eye Strain
- ❒ Floaters or Spots
- ❒ Fluctuating Vision
- ❒ Itching Eyes
- ❒ Light Sensitivity
- ❒ Poor Night Vision
- ❒ Red Eyes
- ❒ Seeing Flashes or Halos
- ❒ Styes
- ❒ Temporary Loss of Vision
- ❒ Twitching Eyelid
- ❒ Watery Eyes

Cancer	❒	❒
Cataracts	❒	❒
Chemical Dependency	❒	❒
Depression / Anxiety	❒	❒
Diabetes	❒	❒
Emphysema	❒	❒
Epilepsy	❒	❒
Glaucoma	❒	❒
Headaches	❒	❒
Head Injury	❒	❒
Heart Condition / or Pacemaker		❒
Hepatitis (Type _____)		❒
Herpes	❒	❒
High Blood Pressure	❒	❒
High Cholesterol	❒	❒

Macular Degeneration		❒
Multiple Sclerosis	❒	❒
Myasthenia Gravis	❒	❒
Pacemaker	❒	❒
Sickle Cell or Trait	❒	❒
Shingles	❒	❒
Skin Disorder	❒	❒
Stroke	❒	❒
Thyroid Condition	❒	❒
Ulcers	❒	❒

❒ Other _____

Are you pregnant? ❒ Yes ❒ No Number of children _____

Do you use tobacco? ❒ Yes ❒ No

Do you use alcohol? ❒ Yes ❒ No

ALLERGIES / SENSITIVITIES

Please place a "√" in any ❒ to indicate if you have any allergies or sensitivities in the categories below.

- ❒ Drugs (Please List) _____
- ❒ Foods (Please List) _____
- ❒ Seasonal / Environmental (Please include which season bothers you most) _____

MEDICATIONS / VITAMINS / SUPPLEMENTS

Please place a "√" in any ❒ to indicate if you use any prescribed or over-the-counter substances in the categories below.

- ❒ Medications (Please List) _____
- ❒ Vitamins / Supplements (Please List) _____
- ❒ Eye Drops (Please List) _____

– Thank You –