PLEASE PRINT

Month/Year	First 3 Initials of Last Name

Patient Information	LAST NAME		MI	FIRST NAME
PRIOR PATIENT Y N	DATE OF BIRTH (mm/dd/yy)	AGE	GENDER F M	HOME PHONE
ADDRESS				CELL PHONE

VISION INSURANCE PLAN	MEDICAL INSURANCE PLAN
	TODAY'S DATE
Medical and Vision History	REASON FOR TODAY'S VISIT

CURRENT MEDICAL/VISION CONDITIONS/ALLERGIES	CURRENT MEDICATIONS (including eye drops, prescriptions, aspirin, vitamins and over the counter products)
FAMILY MEDICAL HISTORY	DATE OF LAST EYE EXAM (mm/dd/yy)
	PREVIOUS EYE DOCTOR / MEDICAL DOCTOR
Vision and Lifestyle Needs	OCCUPATION

WHAT DO YOU CURRENTLY HAVE FOR VISION CORRECTION?

- ☐ EYEGLASSES
- ☐ CONTACT LENSES
- ☐ OTHER (specify)
- ☐ SUN PROTECTION
- ☐ COMPUTER

HOBBIES AND OTHER VISION TASKS (i.e. computer, sports, reading, needlework, cooking)

THE FOLLOWING SECTION WILL BE COMPLETED WITH THE DOCTOR

MEDICAL AND OCULAR HISTORY

CURRENT CORRECTION(S):	AGE OF SPECTACLES	CONTACT LENSES: BRAND
	TYPE(S)	WEARING SCHEDULE
		AGE OF Rx

Rx:	OD SPH	CYL	AXIS	ADD	PRISM
	OS SPH	CYL	AXIS	ADD	PRISM

CARE SOLUTION(S)

Rx: OD / OS

PRESCRIPTION AND ACUITIES:					ACUITIES WITH LENSES:
UNAIDED ACUITIES:	OD	OS	OU	NEAR	OD 20/
WITH CURRENT Rx:	OD	OS	OU	NEAR	OS 20/
					OU 20/

PATIENT'S OPINION OF COMFORT/FUNCTION WITH CURRENT CORRECTION(S)