*Advanced*Eyecare

For a Lifetime of Healthy Vision

Lawrence D. Reed, O.D.
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Dana J. Krause, O.D.
Jeffrey A. Harter, O.D.
Christine L. Mitts, O.D.
Melissa M. Enevoldsen, O.D.

WELCOME TO OUR OFFICE

(PLEASE PRINT)

Name _____
Street _____
City _____ **State** _____ **Zip** _____
Home Phone _____
Work Phone _____
Social Security Number _____
Employer (or School) _____
Occupation (or Grade) _____
Date of Birth _____ **Age** _____ **Sex: M/F** ____
E-Mail _____
What is your Marital Status? M ___ S ___ D ___ W___

MEDICAL HISTORY

Allergies	☐ No ☐ Yes	Arthritis	☐ No ☐ Yes
Asthma	☐ No ☐ Yes	Cancer	☐ No ☐ Yes
Skin Disorder	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes
Eye Diseases	☐ No ☐ Yes	Heart Disease	☐ No ☐ Yes
Eye Injury	☐ No ☐ Yes	High Blood Pres	☐ No ☐ Yes
Eye Surgery	☐ No ☐ Yes	Kidney	☐ No ☐ Yes
Lazy Eye	☐ No ☐ Yes	Nerve Problems	☐ No ☐ Yes
Cataracts	☐ No ☐ Yes	Other	☐ No ☐ Yes
Glaucoma	☐ No ☐ Yes	_____	

CURRENT MEDICATIONS
Please list all of your medications

(Including non-prescription medications, vitamins, and supplements.)

_____
_____
_____
_____
_____
_____
_____
_____

Who is your physician? _____

FAMILY MEDICAL HISTORY

		RELATIONSHIP
Macular Degeneration	☐ No ☐ Yes	_____
Cataracts	☐ No ☐ Yes	_____
Glaucoma	☐ No ☐ Yes	_____
Diabetes	☐ No ☐ Yes	_____
Heart Disease	☐ No ☐ Yes	_____

Date of Last Exam _____ **Date** _____

What specific problems are you having with your eyes, vision, glasses, and /or contact lenses?

_____
_____

Spouse (or Parent) Name _____
Spouse (or Parent) Work Phone _____
Vision Insurance _____

Do you have a flexible spending account or cafeteria plan at your work? ☐ Yes ☐ No

How will you settle your account today?
☐ Check ☐ Cash ☐ Credit/Debit Card

Do you . . .

..Have a spare pair of glasses?	☐ Yes ☐ No
..Have prescription sunglasses?	☐ Yes ☐ No
..Have problems with glare or reflections from your glasses? (particularly when driving at night)	☐ Yes ☐ No
..Want information on thinner/lighter lenses?	☐ Yes ☐ No
..Spend a lot of time outdoors?	☐ Yes ☐ No
..Wear lined bifocals or trifocals?	☐ Yes ☐ No
..If yes, are you interested in trying progressive/ no line lenses?	☐ Yes ☐ No
..Have family members in need of eye care?	☐ Yes ☐ No

Have you ever worn / are you currently wearing contacts? ☐ Yes ☐ No

What kind? _____ Solutions used _____

Are you interested in . . .

..Contact Lenses?	☐ Yes ☐ No
..Refractive Surgery?	☐ Yes ☐ No

Do you experience . . .

☐ Blurry distance vision	☐ Burning
☐ Blurry near vision	☐ Itching
☐ Trouble seeing at night	☐ Watering
☐ Reading problems	☐ Dryness
☐ Sensitivity to light	☐ Redness
☐ Glare or reflections	☐ Sudden loss of vision
☐ Uncomfortable glasses	☐ Objects floating in vision
☐ Uncomfortable contact lenses	☐ Light Flashes
☐ Gritty feeling in eyes	☐ Eyestrain
☐ Headaches	☐ Double Vision

☐ Other: _____

How did you first hear about our office?
☐ Friend or Relative. Who? _____
☐ Another Health Care Provider. Who? _____
☐ Yellow Pages. Which Directory? _____
☐ Print Advertisement. _____
☐ Radio / TV. Which station? _____
☐ Previous Patient. Who? _____
☐ Other _____

BS - 0006

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WELCOME BACK TO OUR OFFICE

Please complete the appropriate section below to update your health history and current eye problems.

(PLEASE PRINT)

Date:_____

Please List All Of Your Medications.
(Including non-prescription medications, vitamins, and supplements.)

_____
_____
_____
_____

Please list any changes to your health history since your last exam.

_____
_____

Do You Currently Experience. . .	**Y**	**N**
Blurry distance vision?	☐	☐
Blurry near vision?	☐	☐
Dryness?	☐	☐
Burning?	☐	☐
Excess tearing?	☐	☐
Are You Aware Of. . .		
Seeing objects floating in your vision?	☐	☐
Seeing flashes of light?	☐	☐
Problems with glare or reflections?	☐	☐
Do You . . .		
Work at a computer for long periods?	☐	☐
Have a spare pair of glasses?	☐	☐
Have sunglasses with a current prescription?	☐	☐
Have an interest in being fit for contact lenses? (If not already wearing contacts)	☐	☐

Date:_____

Please List All Of Your Medications.
(Including non-prescription medications, vitamins, and supplements.)

_____
_____
_____
_____
_____

Please list any changes to your health history since your last exam.

_____
_____

Do You Currently Experience. . .	**Y**	**N**
Blurry distance vision?	☐	☐
Blurry near vision?	☐	☐
Dryness?	☐	☐
Burning?	☐	☐
Excess tearing?	☐	☐
Are You Aware Of. . .		
Seeing objects floating in your vision?	☐	☐
Seeing flashes of light?	☐	☐
Problems with glare or reflections?	☐	☐
Do You . . .		
Work at a computer for long periods?	☐	☐
Have a spare pair of glasses?	☐	☐
Have sunglasses with a current prescription?	☐	☐
Have an interest in being fit for contact lenses? (If not already wearing contacts)	☐	☐

Date:_____

Please List All Of Your Medications.
(Including non-prescription medications, vitamins, and supplements.)

_____
_____
_____
_____
_____

Please list any changes to your health history since your last exam.

_____
_____

Do You Currently Experience. . .	**Y**	**N**
Blurry distance vision?	☐	☐
Blurry near vision?	☐	☐
Dryness?	☐	☐
Burning?	☐	☐
Excess tearing?	☐	☐
Are You Aware Of. . .		
Seeing objects floating in your vision?	☐	☐
Seeing flashes of light?	☐	☐
Problems with glare or reflections?	☐	☐
Do You . . .		
Work at a computer for long periods?	☐	☐
Have a spare pair of glasses?	☐	☐
Have sunglasses with a current prescription?	☐	☐
Have an interest in being fit for contact lenses? (If not already wearing contacts)	☐	☐