Eye Candy Optical Center

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☐**New Patient** ☐**Previous Patient** Date_____

*Last Name*_____ *First Name*_____

*Address*_____ *DOB*_____
Street Address City State zip

*Home Phone*_____ *Cell Phone*_____ *Occupation*_____

*Insurance*_____ *Social Security #*_____

e-mail_____

How did you learn about our office?_____ *Date of last vision exam*?_____

Your reasons for visiting our office today? (please check appropriate items)

_____Routine Examination (no specific problems)	_____Distance Vision Blurry	_____Eyes feel dry
	_____Near Vision Blurry	_____Eye pain or redness
_____Need new glasses	_____Eye feel tired / fatigue	_____Headaches
_____Excessive computer work	_____Flashes of Light	
_____Need new contact lenses	_____Glare while driving/computer	
_____Problems with current contacts	_____Eyes Itch and Burn	Other_____

Do you have a back-up pair of glasses? ☐ Yes ☐ No

What do you currently use for sun wear*?* _____

Are you interested in trying contact lenses? ☐ Yes ☐ No

Are you interested in trying color contact lenses? ☐ Yes ☐ No

Please indicate if you or any blood relatives have:

	You	**Relative**		**You**	**Relative**
Diabetes	☐ yes / no ☐	☐ yes / no ☐	Eye Injuries	☐ yes / no ☐	☐ yes / no ☐
High Blood Pressure	☐ yes / no ☐	☐ yes / no ☐	Eye Surgeries	☐ yes / no ☐	☐ yes / no ☐
Multiple Sclerosis	☐ yes / no ☐	☐ yes / no ☐	Cataracts	☐ yes / no ☐	☐ yes / no ☐
Thyroid Problems	☐ yes / no ☐	☐ yes / no ☐	Glaucoma	☐ yes / no ☐	☐ yes / no ☐
Sinus Problems	☐ yes / no ☐	☐ yes / no ☐	Retinal Problems	☐ yes / no ☐	☐ yes / no ☐
Migraines	☐ yes / no ☐	☐ yes / no ☐	Lazy Eye	☐ yes / no ☐	☐ yes / no ☐
Heart Disease	☐ yes / no ☐	☐ yes / no ☐	Macular Degeneration	☐ yes / no ☐	☐ yes / no ☐
			Other_____		

Do you have allergies? ☐ Yes ☐ No If yes,what kind?_____

Privacy Notice/Authorization of payment

The Notice of Privacy Practices of this office is presented in written form to all patients before they see the doctor. I authorize my insurance company to pay directly to the doctor the benefits otherwise payable to me. I assume financial responsibility for payment of all services rendered if my insurance carrier refuses payment on my and/or the behalf of dependents. By signing below, I acknowledge the Notice of Privacy Practices.

Signed_____ Date_____
(Self or parent if a minor)

Please list all medications that you are currently taken.

_____
_____
_____

Are you allergic to any medications?

YES OR NO

If yes please list: _____

DRY EYE SURVEY

Do your eyes ever experience?

Gritty or sandy sensations? ☐Never ☐Slight ☐Moderate ☐Severe

Pain or soreness? ☐Never ☐Slight ☐Moderate ☐Severe

Fluctuating vision? ☐Never ☐Slight ☐Moderate ☐Severe

Blurred vision while reading? ☐Never ☐Slight ☐Moderate ☐Severe

Discomfort in windy conditions? ☐Never ☐Slight ☐Moderate ☐Severe

Discomfort in air conditioned areas? ☐Never ☐Slight ☐Moderate ☐Severe

ALLERGY SURVEY

Do you EVER suffer from red, itchy, watery eyes or swollen eyelids?

☐YES ☐NO

Do you take over the counter or prescribed eye drops to treat red, itchy, watery eyes or swollen eyelids?

☐YES ☐NO

Do you take over the counter or prescribed allergy medications?

☐YES ☐NO